SERFF Tracking Number:	*ICCI-126869662*	*State:*	*Arkansas*
Filing Company:	*Madison National Life Insurance Company, Inc.*	*State Tracking Number:*	*47297*
Company Tracking Number:	*MNL MMHI POL D610*		
TOI:	*H14G Group Health - Hospital Indemnity*	*Sub-TOI:*	*H14G.000 Health - Hospital Indemnity*
Product Name:	*MNL MMHI POL D610 - Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/MNL MMHI POL D610*		

Filing at a Glance

Company: Madison National Life Insurance Company, Inc.

Product Name: MNL MMHI POL D610 - Hospital Indemnity Policy	SERFF Tr Num: ICCI-126869662	State: Arkansas
TOI: H14G Group Health - Hospital Indemnity	SERFF Status: Closed-Approved-Closed	State Tr Num: 47297
Sub-TOI: H14G.000 Health - Hospital Indemnity	Co Tr Num: MNL MMHI POL D610	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Brenda Dawson	Disposition Date: 11/22/2010
	Date Submitted: 11/11/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Hospital Indemnity Policy	Status of Filing in Domicile:
Project Number: MNL MMHI POL D610	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Association
Filing Status Changed: 11/22/2010	Explanation for Other Group Market Type:
	State Status Changed: 11/22/2010
Deemer Date:	Created By: Brenda Dawson
Submitted By: Brenda Dawson	Corresponding Filing Tracking Number:

Filing Description:

Enclosed is a filing for the above referenced forms. These forms are new and are not intended to replace any forms previously filed with your Department.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Madison National Life Insurance Company. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc., at the address shown above.

Group Fixed Indemnity Health Insurance Policy form MNL MMHI POL D610 will be issued to an association group

located outside of your state. The Policy may be issued to the Communicating for America Association (CA) previously approved by your Department on 8/28/2007 under SERFF Tracking # ICCI-125266631 and state tracking # 36687, or the America's Business Associatin (ABBA) previously approved by your Department on 6/13/2008 under SERFF Tracking # ICCI-125693274 and state tracking # 39290.

Group Policyholder Application MNL HIGAPP 610, will be completed by the Association to apply for the Policy.

Form MNL HICERT D0610 is the Group Certificate evidencing coverage under the Group Policy. Amendatory Endorsement form MNL HIAR AE 610 will be attached to all Certificates issued in Arkansas.

Form MNL OPT ELC AR 610 will be completed by the Group Policyholder to elect the Optional benefits for TMJ. If elected, Amendatory Endorsement form MNL AEAR OPT TMJ 610 will be attached to the policy and certificate.

Group Limited Benefit Fixed Indemnity Health Insurance Application form MNL HIAPP 610 will be completed by the individual applying for coverage under the Group Policy.

The following Rider Benefit Riders may also be offered to each applicant:

[Optional] Emergency Room Indemnity Benefit Rider – MNL HIER 610
[Optional] Inpatient Confinement Enhancement Indemnity Benefit Rider – MNL HIICE 610
[Optional] Preventive Care Indemnity Benefit Rider – MNL HIPCBR 610
[Optional] Outpatient Physician Office Visit Indemnity Benefit Rider – MNL HIPOV 610
[Optional] Outpatient Prescription Medication Indemnity Benefit Rider – MNL HIRXBR 610
[Optional] Outpatient Diagnostic Testing Indemnity Benefit Rider – MNL HITEST 610

Amendatory Endorsement MNL HI/FI AE 1010 may or may not be included with the coverage depending upon the group and or the marketing program being offered.

This is individual fixed indemnity coverage under a group Association Policy. As such, covered benefits are paid subject to the terms, limitations and exclusions of the Policy, regardless of the amount billed by the health care provider.

The Policy documents were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the actual text of the contract other than listed or bracketed variables, or to the general print size.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

SERFF Tracking Number:	*ICCI-126869662*	*State:*	*Arkansas*
Filing Company:	*Madison National Life Insurance Company, Inc.*	*State Tracking Number:*	*47297*
Company Tracking Number:	*MNL MMHI POL D610*		
TOI:	*H14G Group Health - Hospital Indemnity*	*Sub-TOI:*	*H14G.000 Health - Hospital Indemnity*
Product Name:	*MNL MMHI POL D610 - Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/MNL MMHI POL D610*		

Company and Contact

Filing Contact Information

Brenda Dawson, Authorized Representative — Brendadawson@inscompliance.com
3925 East State Street, Suite 200 — 815-316-6714 [Phone]
Rockford, IL 61108 — 815-986-2355 [FAX]

Filing Company Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Madison National Life Insurance Company, Inc.	CoCode: 65781	State of Domicile: Wisconsin
P. O. Box 5008	Group Code:	Company Type:
Madison, WI 53705	Group Name:	State ID Number:
(800) 356-9601 ext. [Phone]	FEIN Number: 39-0990296	

Filing Fees

Fee Required?	Yes
Fee Amount:	$850.00
Retaliatory?	No
Fee Explanation:	$50 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Madison National Life Insurance Company, Inc.	$850.00	11/11/2010	41800408

SERFF Tracking Number:	*ICCI-126869662*	*State:*	*Arkansas*
Filing Company:	*Madison National Life Insurance Company, Inc.*	*State Tracking Number:*	*47297*
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Product Name:	*MNL MMHI POL D610 - Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/MNL MMHI POL D610*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/22/2010	11/22/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	11/19/2010	11/19/2010	Brenda Dawson	11/22/2010	11/22/2010

SERFF Tracking Number:	*ICCI-126869662*	*State:*	*Arkansas*
Filing Company:	*Madison National Life Insurance Company, Inc.*	*State Tracking Number:*	*47297*
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Product Name:	*MNL MMHI POL D610 - Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/MNL MMHI POL D610*		

Disposition

Disposition Date: 11/22/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ICCI-126869662*	*State:*	*Arkansas*
Filing Company:	*Madison National Life Insurance Company, Inc.*	*State Tracking Number:*	*47297*
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Product Name:	*MNL MMHI POL D610 - Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/MNL MMHI POL D610*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Group Hospital Indemnity Policy	Approved-Closed	Yes
Form	Group Hospital Indemnity Certificate	Approved-Closed	Yes
Form	[Optional] Emergency Room Indemnity Benefit Rider	Approved-Closed	Yes
Form	[Optional] Inpatient Confinement Enhancement Indemnity Benefit Rider	Approved-Closed	Yes
Form	[Optional] Preventive Care Indemnity Benefit Rider	Approved-Closed	Yes
Form	[Optional] Physician Office Visit Indemnity Benefit Rider	Approved-Closed	Yes
Form	[Optional] Prescription Medication Indemnity Benefit Rider	Approved-Closed	Yes
Form	[Optional] Outpatient Testing Indemnity Benefit Rider	Approved-Closed	Yes
Form	Amendatory Exclusion Endorsement	Approved-Closed	Yes
Form	Rescission Endorsement	Approved-Closed	Yes
Form	Benefit Selection Form	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Group Application	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes
Form *(revised)*	Group Policyholder Election form for TMJ	Approved-Closed	Yes
Form	Group Policyholder Election form for TMJ	Replaced	Yes
Form	Optional coverage rider for TMJ	Approved-Closed	Yes

SERFF Tracking Number:	*ICCI-126869662*	*State:*	*Arkansas*
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Product Name:	*MNL MMHI POL D610 - Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/MNL MMHI POL D610*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/19/2010
Submitted Date	11/19/2010
Respond By Date	

Dear Brenda Dawson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application, MNL HIAPP 610 (Form)

Comment:

With respect to the mandated offering for TMJ, please review ACA 23-79-150 (c)(1)(2).

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*ICCI-126869662*	*State:*	*Arkansas*
Filing Company:	*Madison National Life Insurance Company, Inc.*	*State Tracking Number:*	*47297*
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Product Name:	*MNL MMHI POL D610 - Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/MNL MMHI POL D610*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/22/2010
Submitted Date	11/22/2010

Dear Rosalind Minor,

Comments:
Thank you for your letter.

Response 1

Comments: Please find attached revised Group Policyholder Election form MNL OPT ELC AE 610. This form was revised to include "Rejection of this option means that covered benefit provided to the Covered Person will not include temporomandibular joint (TMJ) disorder of craniomandibular disorder."

Related Objection 1

Applies To:

- Application, MNL HIAPP 610 (Form)

Comment:

With respect to the mandated offering for TMJ, please review ACA 23-79-150 (c)(1)(2).

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Policyholder Election form for TMJ	MNL OPT ELC AR 610		Certificate Amendment, Insert Page, Endorsement or Rider	Initial			AR MNL OPT ELC AR 610 _Optional

SERFF Tracking Number:	*ICCI-126869662*	*State:*	*Arkansas*
Filing Company:	*Madison National Life Insurance Company, Inc.*	*State Tracking Number:*	*47297*
Company Tracking Number:	*MNL MMHI POL D610*		
TOI:	*H14G Group Health - Hospital Indemnity*	*Sub-TOI:*	*H14G.000 Health - Hospital Indemnity*
Product Name:	*MNL MMHI POL D610 - Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/MNL MMHI POL D610*		

Election form_ 11-22-10.pdf

Previous Version

Group Policyholder Election form for TMJ	*MNL OPT ELC AR 610*	*Certificate Amendment, Initial Insert Page, Endorsement or Rider*	AR MNL OPT ELC AR 610 _Optional Election form_.pdf

No Rate/Rule Schedule items changed.

Your continued review for approval is greatly appreciated. Thank you.

Sincerely,
Brenda Dawson

SERFF Tracking Number:	*ICCI-126869662*	*State:*	*Arkansas*
Filing Company:	*Madison National Life Insurance Company, Inc.*	*State Tracking Number:*	*47297*
Company Tracking Number:	*MNL MMHI POL D610*		
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Product Name:	*MNL MMHI POL D610 - Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/MNL MMHI POL D610*		

Form Schedule

Lead Form Number: MNL MMHI POL D610

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/22/2010	MNL MMHI POL D610	Policy/Contract/Fraternal Certificate	Group Hospital Indemnity Policy	Initial		0.000	MNL MMHI POL D610.pdf
Approved-Closed 11/22/2010	MNL HICERT D0610	Certificate	Group Hospital Indemnity Certificate	Initial		0.000	MNL HICERT D610 _HospitalIndemnityCert_.pdf
Approved-Closed 11/22/2010	MNL HIER 610	Certificate Amendment, Insert Page, Endorsement or Rider	[Optional] Emergency Room Indemnity Benefit Rider	Initial		0.000	MNL HIER 610 _EmergencyRoomBenefitRider_061810.pdf
Approved-Closed 11/22/2010	MNL HIICE 610	Certificate Amendment, Insert Page, Endorsement or Rider	[Optional] Inpatient Confinement Enhancement Indemnity Benefit Rider	Initial		0.000	MNL HIICE 610 _InpatientConfinementEnhancementBenefitRider_061810.pdf
Approved-Closed 11/22/2010	MNL HIPCBR 610	Certificate Amendment, Insert Page, Endorsement or Rider	[Optional] Preventive Care Indemnity Benefit Rider	Initial		0.000	MNL HIPCBR 610 _PreventiveCareBenefitRider_061810.pdf
Approved-Closed 11/22/2010	MNL HIPOV 610	Certificate Amendment, Insert	[Optional] Physician Office Visit Indemnity Benefit Rider	Initial		0.000	MNL HIPOV 610 _PhysicianOff

		Page, Endorsement or Rider				iceVisitBenefit Rider_061810.pdf
Approved-Closed 11/22/2010	MNL HIRXBR 610	Certificate Amendment, Insert Page, Endorsement or Rider	[Optional] Prescription Medication Indemnity Benefit Rider	Initial	0.000	MNL HIRXBR 610 _PrescriptionMedicationBenefitRider_061810.pdf
Approved-Closed 11/22/2010	MNL HITEST 610	Certificate Amendment, Insert Page, Endorsement or Rider	[Optional] Outpatient Testing Indemnity Benefit Rider	Initial	0.000	MNL HITEST 610 _OutpatientTestingBenefitRider_061810.pdf
Approved-Closed 11/22/2010	MNL HIEXCL AE 610	Certificate Amendment, Insert Page, Endorsement or Rider	Amendatory Exclusion Endorsement	Initial	0.000	MNL HIEXCL AE 610 _HIP Exclusion Endorsement _062210.pdf
Approved-Closed 11/22/2010	MNL HIRE 610	Certificate Amendment, Insert Page, Endorsement or Rider	Rescission Endorsement	Initial	0.000	MNL HIRE 610 _HIP RescissionEndorsement__062210_.pdf
Approved-Closed 11/22/2010	MNL HIBSF 610	Application/ Enrollment Form	Benefit Selection Form	Initial	0.000	MNL HIBSF 610 _HospitalIndemnityBenefitSelection_070710.pdf
Approved-Closed 11/22/2010	MNL HIAPP 610	Application/ Enrollment Form	Application	Initial	0.000	MNL HIAPP 610 _HIP Application_10-28-10.pdf
Approved-	MNL	Application/	Group Application	Initial	0.000	MNL HIGAPP

SERFF Tracking Number:	*ICCI-126869662*		*State:*	*Arkansas*			
Filing Company:	*Madison National Life Insurance Company, Inc.*		*State Tracking Number:*	*47297*			
Company Tracking Number:	*MNL MMHI POL D610*						
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Product Name:	*MNL MMHI POL D610 - Hospital Indemnity Policy*						
Project Name/Number:	*Hospital Indemnity Policy/MNL MMHI POL D610*						
Closed 11/22/2010	HIGAPP 610	Enrollment Form					610 _Group Application_.pdf
Approved-Closed 11/22/2010	MNL HI/FI AE 1010	Certificate Amendment, Insert Page, Endorsement or Rider	Amendatory Endorsement	Initial		0.000	MNL HI-FI AE 1010.pdf
Approved-Closed 11/22/2010	MNL HIAR AE 610	Certificate Amendment, Insert Page, Endorsement or Rider	Amendatory Endorsement	Initial			AR MNL HIAR AE 610.pdf
Approved-Closed 11/22/2010	MNL OPT ELC AR 610	Certificate Amendment, Insert Page, Endorsement or Rider	Group Policyholder Election form for TMJ	Initial			AR MNL OPT ELC AR 610 _Optional Election form_ 11-22-10.pdf
Approved-Closed 11/22/2010	MNL AEAR OPT TMJ 610	Certificate Amendment, Insert Page, Endorsement or Rider	Optional coverage rider for TMJ	Initial			AR MNL AEAR OPT TMJ 610.pdf

MADISON NATIONAL LIFE INSURANCE COMPANY, INC

[P.O. Box 5008, Madison, WI 53705]

(Herein called We, Our, Us or the Company)

POLICYHOLDER: [ABC Association]

POLICY NUMBER: [XX-XXXXX]

EFFECTIVE DATE: [June 1, 2010]

STATE OF DELIVERY: [District of Columbia]

In consideration of the Master Group Policy Application made by the Policyholder, and in consideration of the payment of any applicable premium due, We agree to pay the group insurance benefits herein with respect to each Covered Person, in accordance with and subject to the terms, conditions and limitations of the Policy. Benefits are payable in United States dollars only.

The Policy becomes effective at 12:01 a.m. Standard Time at the Policyholder's address on the Effective Date shown above, and will remain in force until it is terminated by [sixty (60)] days written notice to the Policyholder or Us. The Policy renews monthly following the Effective Date shown above.

This Policy is governed by the laws of the jurisdiction of the State of delivery.

This face page and all endorsements, Riders, Schedule of Benefits, Certificates, applications and any addendums, form the Master Policy. These pages are all part of this Policy as if fully recited over the signature shown below.

Executed for Madison National Life Insurance Company, Inc., as of the Effective Date.

GROUP FIXED INDEMNITY HEALTH INSURANCE BENEFITS

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Larry R. Graber
President

Adam C. Vandervoort
Secretary

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

[**P.O. Box 5008, Madison, WI 53705**]

CERTIFICATE OF INSURANCE

Madison National Life Insurance Company, Inc., herein called The Company, hereby certifies that it has issued and delivered to the Policyholder a group Policy, described on the Schedule of Benefits page. The group Policy covers certain Covered Persons as described in the Policy.

This Certificate describes the Benefits and provisions of the Policy. This Certificate becomes effective only if: (1) the Eligible Person is eligible for insurance; (2) We have received the Eligible Person's application/enrollment form; (3) the required premium has been paid; and (4) the Eligible Person becomes insured in accordance with all of the provisions of the Policy. No agent may change the Policy or waive its provisions.

[10-30] Day Right To Return

Carefully read this Certificate including all provisions, Benefits and limitations as soon as You receive it. It is important that You understand and are satisfied with the coverage provided under the Policy. If You are not satisfied with this Certificate, return it to The Company at its home office within [10-30] days after You receive it. All premiums will be refunded and coverage will be considered to be void from the beginning.

IMPORTANT NOTICE

The application attached to this Certificate must be carefully reviewed. If any information shown on the application for You or Your Dependents is not correct or is incomplete, or if any medical history has not been included, You must detail the inaccurate or omitted information, and send it to Us at Our authorized administrator's office within 10 days of receipt of this Certificate. The coverage under the Policy is issued on the basis that the answers to all questions, and any other information requested on the application, is correct and complete. [**Omissions or misstatements in the application may cause Rescission or Reformation of Coverage. Please see Section [8] – General Provisions.**]

Group Fixed Hospital Indemnity Health Insurance

LIMITED BENEFIT, PLEASE READ CAREFULLY

THIS FACE PAGE SUPERSEDES AND REPLACES ANY AND ALL PREVIOUSLY ISSUED TO THE ELIGIBLE PERSON

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Larry R. Graber
President

Adam C. Vandervoort
Secretary

Table of Contents

Schedule of Benefits
Hospital Indemnity Benefits Per Covered Person

Name of Eligible Person (Certificate-holder): [John Doe]	**Covered Dependents: [Mary Doe, Spouse][James Doe, Child]**
Eligible Person's Coverage Effective Date: [June 1, 2010]	**[Dependent's Coverage Effective Date: [June 1, 2010]]**
[Certificate Number: [123456]]	**[Plan Chosen: [1, 2, 3]]**
Policyholder: [ABC Association]	**Group Policy Number: [GP002]**
Per Injury or Illness Lifetime Maximum Benefit:	[$200,000-$500,000]
Per Injury or Illness Deductible:	[$250-$10,000]

[Pre-certification Penalty Amounts:
Failure to Pre-certify each Inpatient Hospital confinement: [Not Applicable] [$500*****] [No Benefits are payable*]
[Failure to Pre-certify each Skilled Nursing Facility Inpatient confinement: [Not Applicable] [$500*****] [No Benefits are payable*]]
[Failure to Pre-certify each Home Health Care services: [Not Applicable] [$500***]** [No Benefits are payable*]]
[Failure to Pre-certify Hospice Care Services: [Not Applicable] [$500*****] [No Benefits are payable*]]
[Failure to Pre-certify Outpatient chemotherapy or radiation treatment: [Not Applicable] [$500*] [No Benefits are payable*]]

*****This Penalty Amount does not apply when the Covered Person complies with the Pre-Certification Requirements]

UNLESS OTHERWISE STATED, ALL BENEFITS ARE SUBJECT TO THE PER INJURY OR ILLNESS DEDUCTIBLE FOR EACH PERIOD OF TREATMENT, AND ARE PAYABLE UP TO THE PER INJURY OR ILLNESS LIFETIME MAXIMUM BENEFIT.

Daily Hospital Room and Board (DRB) Indemnity Benefit: [$200,- $1,000] per day

[Daily Hospital Intensive Care Indemnity Benefit: [[2-4] times the DRB Indemnity Benefit] [$400 - $4,000] per day]

[Miscellaneous Hospital Services Inpatient Indemnity Benefit: [[1-4] times the DRB Indemnity Benefit] [$200 - $4,000] per day]

[Inpatient Surgeon Indemnity Benefit: [[2-15] times the DRB Indemnity Benefit] [$400-$15,000] per Surgery]

[Outpatient Surgeon Indemnity Benefit: [[2-6] times the DRB Indemnity Benefit] [$200-$6,000] per Surgery]

[Outpatient Surgery Facility Indemnity Benefit: [[1-6] times the DRB Indemnity Benefit] [$200-$6,000] per Surgery]

[Assistant Surgeon Inpatient Indemnity Benefit: [Benefit is equal to [20%-50%] of the Benefit paid under the Inpatient Surgeon Indemnity Benefit] [$200-$3,000] per Surgery]

[Assistant Surgeon Outpatient Indemnity Benefit: [Benefit is equal to [20%-50%] of the Benefit paid under the Outpatient Surgeon Indemnity Benefit.] [$80-$800] per Surgery]

[Anesthesiologist Inpatient Indemnity Benefit: [Benefit is equal to [20%-50%] of the Benefit paid under the Inpatient Surgeon Indemnity Benefit] [$300-$4,500] per Surgery]

[Anesthesiologist Outpatient Indemnity Benefit: [Benefit is equal to [20%-50%] of the Benefit paid under the Outpatient Surgeon Indemnity Benefit] [$120-$1,200] per Surgery]

[Doctor Visit while Hospital Confined Indemnity Benefit: [[10%-25%] of the DRB Indemnity Benefit] [[$20-$100] per visit]
[Limited to [1] Inpatient Doctor visit per day]]

[Second Surgical Opinion Office Visit Indemnity Benefit: [$50-$200] The Per Injury or Illness Deductible does not apply to this Benefit.]

[Ambulance Transport Indemnity Benefit: [[$50- $500] per [conveyance] [trip] [air] [ground] [water] [occurrence]]

[Outpatient Physical, Speech and Occupational Therapy Indemnity Benefit: **[**[$25-$75] per therapy treatment, up to [15-30] treatments for any one type of therapy, and up to [45-60] treatments combined for any combination of therapies]]

[Continued Care Benefit:

[Skilled Nursing Care: [$50-$200] per day, and up to [30-75] days per Injury or Illness]

[Private Duty Nursing Care: [$50-$200] per shift, and up to [20-50] eight hour shifts per Injury or Illness]

[Home Health Care: [$50-$200] per visit, and up to [60-90] visits per Injury or Illness]

[Hospice Care Services: [$1,000-$3,000] Lifetime Maximum Benefit; this Benefit is paid once while the Covered Person is covered under the Policy]]

[Outpatient Chemotherapy and Radiation Therapy for Cancer Treatment Daily Indemnity Benefit: [[1-3] times the DRB Indemnity Benefit] [[$200-$3,000] per treatment, up to a Lifetime Maximum Benefit of [50-200] treatments.]]

[Critical Illness Deductible Waiver: [Subject to a [6]-month Benefit waiting period] [[50%-100%] of the Per Injury or Illness Deductible is waived for the initial Period of Treatment, limited to one Deductible waiver during the [Eligible] [Covered] Person's lifetime while covered under the Policy.]]

[[OPTIONAL] BENEFIT RIDERS:]

[Outpatient Prescription Medication Indemnity Benefit Rider: [Not Included] [Included]
Outpatient Prescription Medication Indemnity Benefit: [The Per Injury or Illness Deductible does not apply to this Benefit.]

[Outpatient Prescription Medication Calendar Year Deductible: [Not Applicable] [[$50-$250] per Covered Person [for each [Generic Medication] [Formulary Brand Drugs] [Non-Formulary Brand Drugs] [and] [Specialty Medications]]]

[Outpatient Prescription Medication Calendar Year Deductible Family Maximum: [Not Applicable] [Satisfied when [1-4] Covered Persons have each satisfied their Outpatient Prescription Medication Calendar Year Deductible]]

[Generic Medication Benefit: [$4-$200] per each Generic Medication purchased, [up to a Calendar Year Maximum Benefit of [2-10] Generic Medications per Covered Person,] [and up to a Calendar Year Maximum Benefit of [6-20] Generic Medications combined for all Covered Persons.]]

[Formulary Brand Drugs Benefit: [$10-$200] per each Formulary Brand Drugs purchased, [up to a Calendar Year Maximum Benefit of [2-10] Formulary Brand Drugs per Covered Person,] [and up to a Calendar Year Maximum Benefit of [6-20] Formulary Brand Drugs combined for all Covered Persons.]]

[Non-Formulary Brand Drugs Benefit: [$10-$200] per each Non-Formulary Brand Drugs purchased, [up to a Calendar Year Maximum Benefit of [2-10] Non-Formulary Brand Drugs per Covered Person,] [and up to a Calendar Year Maximum Benefit of [6-20] Non-Formulary Brand Drugs combined for all Covered Persons.]]

[Specialty Medications Benefit: [$10-$200] per each Specialty Medications purchased, [up to a Calendar Year Maximum Benefit of [2-10] Specialty Medications per Covered Person,] [and up to a Calendar Year Maximum Benefit of [6-20] Specialty Medications combined for all Covered Persons.]]

[Outpatient Prescription Medication Calendar Year Maximum Benefit: [2-10] combined Prescription Medications purchased per Covered Person [and up to [6-20] combined Prescription Medications for all Covered Persons]]][per Calendar Year]

[Physician Office Visit Indemnity Benefit Rider: [Not Included] [Included]
Physician Office Visit Indemnity Benefit: [[$25-$75] per visit, up to a Calendar Year Maximum Benefit of [1-4] visits per Eligible Person and [per] Covered Dependent Spouse [combined], and [2-6] visits per Covered Dependent Child] [The Per Injury or Illness Deductible does not apply to this Benefit.]]

[Emergency Room Indemnity Benefit Rider: [Not Included] [Included]
Emergency Room Indemnity Benefit: [[20%-50%] of DRB Indemnity Benefit] [$50-$300] per Emergency Room visit [up to a Calendar Year Maximum Benefit of [2-6] Emergency Room visits per Covered Person.] [The Per Injury or Illness Deductible does not apply to this Benefit.]]

[Outpatient Diagnostic Testing Indemnity Benefit Rider: [Not Included] [Included]
Outpatient Diagnostic Testing Indemnity Benefit:

[Outpatient Diagnostic X-ray and Laboratory Tests: [$50-$200] per [test] [visit], [up to a Calendar Year Maximum Benefit of [2-4] [tests] [visits] per Covered Person.]]

[Outpatient Advanced Study Tests: [$250-$2,000] per [test] [visit] [up to a Calendar Year Maximum Benefit of [1-4] [tests] [visits] per Covered Person.]]

[Inpatient Confinement Enhancement Indemnity Benefit Rider: [Not Included] [Included]
Inpatient Confinement Enhancement Indemnity Benefit: [Benefit is payable after the Covered Person's Inpatient confinement during a Period of Treatment exceeds [30-90] days.]

Daily Hospital Room and Board Indemnity Benefit: [[1-4] times the DRB Indemnity Benefit] [[$400 -$4,000] per day].

Daily Hospital Intensive Care Indemnity Benefit: [[2-4] times the Daily Hospital Intensive Care Indemnity Benefit] [[$400-$4,000] per day]

Miscellaneous Hospital Services Inpatient Indemnity Benefit: [[1-4] times the Miscellaneous Hospital Services Indemnity Benefit] [[$400 -$4,000] per day]]

[Preventive Care Indemnity Benefit Rider: [Not Included] [Included]
[Benefit is payable after the Covered Person has been covered under the Benefit Rider for [3-9] consecutive months] [The Per Injury or Illness Deductible does not apply to this Benefit.]
Preventive Care Indemnity Benefit: [$100-$400] per [visit] [test] [up to a Calendar Year Maximum Benefit of [2-4] [visits] [tests] per Covered Person]]

Section 1

Definitions

Accidental Bodily Injury/Injury: A sudden, unexpected and unintended bodily Injury resulting directly from an accident which is independent of any Illness and which takes place while the Covered Person's coverage is in force.

Advanced Study/Studies: Those procedures in the CPT Code [90000] Series excluding Preventive Care and limited to: [Angiogram; Arteriogram; Computed Tomography Scan (CT); Electroencephalogram (EEG); Magnetic Resonance Imaging (MRI); Myelogram; Positron Emission Tomography Scan (PET); and Thallium Stress Test.]

Ambulatory Surgical Center: Any public or private establishment with:
1. An organized medical staff of Doctors;
2. Permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
3. Continuous Doctors' services whenever a patient is in the facility; and
4. No services or accommodations for patients to stay overnight.

Benefit: The dollar amount payable by Us to an Eligible Person or assignee of an Eligible Person under the Policy.

Calendar Year: The period of time beginning January 1st and ending on December 31st of the same year. The first Calendar Year of the Certificate will begin on the date Your coverage becomes effective and end on the first December 31st after a Covered Person's Effective Date of coverage.

Calendar Year Maximum Benefit: The maximum Benefit payable for specific Covered Benefits as shown on the Schedule of Benefits.

Certificate: The Certificate of Insurance given to the Eligible Person. It describes the Benefits and provisions of the Policy for the Eligible Person and Dependents, if any.

Child:
1. An Eligible Person's natural Child;
2. An Eligible Person's lawfully adopted Child;
3. A Child placed for adoption with an Eligible Person;
4. An Eligible Person's stepchild;
5. An Eligible Person's foster Child;
6. A Child for whom the Eligible Person has been appointed legal guardian by a court of competent jurisdiction and who resides with and who is dependent upon the Eligible Person in a regular parent-child relationship; or
7. A Child of the Eligible Person for whom the Eligible Person is obligated to provide medical Child support pursuant to a Qualified Medical Support Order.

Clinical Diagnosis: A Diagnosis of Life Threatening Cancer based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Cancer only if the following conditions are met: a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening; there is medical evidence to support the Diagnosis; and a Legally Qualified Physician is treating the Covered Person for Life Threatening Cancer.

Coma: The Diagnosis, by a Legally Qualified Physician board-certified as a Neurologist, that a Covered Person is in a state of unconsciousness from which the Covered Person cannot be aroused, in which external stimulation will produce no more than primitive avoidance reflexes, and that this state has persisted continuously for at least 96 hours.

Complications of Pregnancy: (1) Conditions (when Pregnancy is not terminated) whose diagnoses are distinct from Pregnancy but are adversely affected by or caused by Pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion hyperemesis gravidarum, preeclampsia, and similar medical and surgical conditions of comparable severity; and (2) non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of Pregnancy which occurs during a period of gestation in which a viable birth is not possible.

"Complications of Pregnancy" does not include false labor, occasional spotting, Doctor**-**prescribed rest during the period of pregnancy, morning sickness, elective cesarean section, and similar conditions associated with the management of a difficult Pregnancy but not constituting a nosologically distinct Complication of Pregnancy.

Coverage Effective Date: The date, starting at 12:01 A.M. at the Eligible Person's residence, that coverage for a Covered Person takes effect under the Policy.

Covered Benefits: Those services or supplies that:
1. Are Medically Necessary;
2. Are received while the Covered Person is insured under the Policy; and
3. Are not excluded under Section 4 – Exclusions and Limitations.

Covered Person: A person who has satisfied all of the following requirements:
1. He or she is eligible for coverage under the Policy, either as an Eligible Person or as a Dependent;
2. He or she has been accepted for coverage under the Policy or has been automatically added;
3. Premium has been paid for him or her; and
4. His or her coverage has become effective and has not terminated.

Covered Persons are shown on the [Identification Card] [and] Schedule of Benefits.

CPT: The Doctor's Current Procedural Terminology published by the American Medical Association, version in effect on the date the service is provided.

Critical Illness: One of the following conditions, as defined herein: Life Threatening Cancer, Heart Attack, Stroke, Kidney (Renal) Failure, and Coma. The [Eligible] [Covered] Person must be positively diagnosed by a Legally Qualified Physician as having a Critical Illness for the first time following the Coverage Effective Date.

Custodial Care: Services (including room and board) or supplies which:
1. Are primarily to help the Covered Person perform the activities of daily living;
2. Can safely be provided by non-skilled persons; and
3. Are not Medically Necessary to reduce the disability.

Daily Room and Board (DRB): The daily benefit paid for any Inpatient accommodations and general nursing furnished by a licensed institution.

Date of Diagnosis: The date the Diagnosis is established by a Legally Qualified Physician through the use of clinical and/or laboratory findings as supported by the Covered Person's medical records. For a procedure, it is the date the Covered Person undergoes the procedure.

Dependent: An Eligible Person's:
1. Spouse;
[2. Unmarried Child who is primarily dependent upon the Eligible Person for support and maintenance and is:
    a. Less than [19] years of age[; or
    b. Between [19] and [26] years of age;] [provided however, that the Child is dependent upon the Eligible Person for support and maintenance]];

[2. Child who is less than [26] years of age.]

Dependent does not include anyone who:
1. Lives outside the United States;
2. Is in the armed forces of any country; or
3. Has coverage under the Policy as an Eligible Person or as a Dependent of another person.

Diagnosis: Is the definitive establishment of the Critical Illness Condition through the use of clinical and/or laboratory findings. The Diagnosis must be made by a Legally Qualified Physician.

Doctor/Physician/Legally Qualified Physician: A person who is:
1. Licensed as a provider of medical services by the state in which he or she practices;
2. Acting within the scope of his or her license;
3. A board certified specialist where required; and
4. Not one of the following:
   a. A person who ordinarily resides in Your household.
   b. A member of Your Immediate Family.

Durable Medical Equipment: Equipment that is customarily used to serve a medical purpose and not generally useful to a person in the absence of an Illness or Injury.

Eligible Person: The primary insured named as the Member on the Schedule of Benefits whose coverage has become effective and has not terminated.

Emergency: The sudden onset of a medical condition manifested by symptoms of such severity that the failure to immediately provide Medically Necessary treatment could reasonably be expected to result in:
1. Placing the Covered Person's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Room: A facility located on the premises of, or physically a part of, a Hospital that provides initial treatment to patients with a broad spectrum of Illnesses and Injuries that require immediate attention and is especially equipped and staffed for Emergency Care.

[Evidence of Insurability: A medical statement that is to be completed to the best of the individual's ability. Evidence of good health is a series of questions regarding the applicant's and/or Dependent's current and previous medical conditions and any treatment they may have received.]

Experimental/Investigational: One or more of the following applies:
1. The medical treatment, surgical procedure, service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include, but are not limited to Phase I, II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the medical treatment, surgical procedure, service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. The Company will determine if this item applies based on:
   a. published reports in authoritative medical literature; and
   b. regulations, reports, publications and evaluations issued by government agencies or professional organizations such as the National Cancer Institute, the Agency for Health Care Policy and Research, the National Institute of Health and the FDA.
3. The provider's institutional review board acknowledges that the use of the medical treatment, surgical procedures, services or supply is Experimental or Investigational and subject to that board's approval.
4. Research protocols indicate that the medical treatment, surgical procedure, service or supply is Experimental or Investigational. This item applies for protocols used by the

Covered Person's provider as well as for protocols used by other providers studying substantially the same medical treatment, surgical procedure, service or supply.

Heart Attack: An acute myocardial infarction resulting in the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart. The Diagnosis must be made by a Legally Qualified Physician board-certified as a Cardiologist and based on both new clinical presentation and electrocardiographic changes consistent with an evolving heart attack; and serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a Diagnosis of Heart Attack. Heart Attack does NOT include an established (old) myocardial infarction.

Hospice Care Services: Home care services provided by professional nurses or home health aides under active management of a Hospice agency licensed and operated pursuant to law and providing a hospice care program of palliative, supportive and interdisciplinary team services. Hospice Care Services does not include services provided by volunteers.

Hospital: An institution that:
1. Operates pursuant to law;
2. Has 24 hour nursing services by registered nurses;
3. Has a staff of one or more Doctors;
4. Provides Inpatient therapeutic and diagnostic services for Illness or Injury;
5. Provides facilities for major surgery or has a formal arrangement with another institution for surgical facilities; and
6. Is approved by the Joint Commission on the Accreditation of Health Care Facilities as a Hospital (JCAHO); the American Hospital Association (AHA); the American Osteopathic Healthcare Association (AOHA); the American Osteopathic Association accreditation (AOA); or the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation.

Hospital does not include any of the following:
1. A rest or nursing home, home for the aged or convalescent home;
2. A Skilled Nursing Facility; an extended care facility; or
3. A hospice, a place for Custodial Care, or a birthing center.

Illness: A sickness or disease or Complications of Pregnancy which requires treatment by a Doctor.

Immediate Family: The Eligible Person's Spouse, or the parent, brother, sister, Child or grandparent of the Eligible Person by blood, marriage or legal adoption; or any person who is a resident in the Eligible Person's household.

Inpatient and Outpatient: The terms "Inpatient" and "Outpatient" refer either to the setting in which medical care is given or to a Covered Person who is receiving care in that setting.

When the terms describe the setting in which medical care is given:
1. "Inpatient" means therapeutic services which are available on a 24-hour basis to a Covered Person while confined in a Hospital or other treatment facility, as a registered bed patient;
2. "Outpatient" means therapeutic services are furnished to a Covered Person while not confined.

When the terms refers to a Covered Person who is receiving medical care:

1. "Inpatient" means a Covered Person who is confined in a Hospital as a registered bed patient for a period of 23 consecutive hours or longer upon the advice of a Doctor for the purpose of other than Custodial Care;
2. "Outpatient" means a Covered Person who is not so confined.

[Intensive Care Unit] [or] [Cardiac Care Unit], [Burn Unit] [or] [Other Specialized Care Unit] of a Hospital: A Cardiac Care Unit or other unit or area of a Hospital which:

1. Is reserved for the seriously ill or injured requiring close observation;
2. Is permanently equipped to provide specialized care by trained qualified personnel and special equipment and supplies on a standby basis;
3. Meets the required standards of the Joint Commission on Accreditation of Hospitals for special care units.

If a Hospital has more than one level of intensive care, the following will be considered as though it were provided in an Intensive Care Unit:

1. Intermediate Intensive Care Unit;
2. Step-down unit; or
3. Similar transitional care unit.

Kidney (Renal) Failure: End Stage (Renal) Failure is a chronic and irreversible failure of both kidneys which requires the [Eligible] [Covered] Person to undergo periodic and ongoing dialysis. The Diagnosis must be made by a Legally Qualified Physician board-certified in Nephrology.

Lab Test/Laboratory Test: A test that is done in the laboratory where the appropriate equipment, supplies and certified expertise are available including those procedures in the CPT Code Range [70000]; but excluding Preventive Care and those procedures in the CPT Code Range [36400-36416] (Venipuncture).

Life Threatening Cancer: A malignant neoplasm is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically excluded. Leukemias and lymphomas are included. Cancer must be diagnosed pursuant to a Pathological or Clinical Diagnosis. Life Threatening Cancer does NOT include: pre-malignant lesions (such as intraepithelial neoplasia), benign tumors or polyps, any skin cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic), or early prostate cancer diagnosed as T1N0M0 or equivalent staging.

Medically Necessary: Treatment, services or supplies provided for an Illness or Injury which:

1. Have been established as safe and effective;
2. Are furnished in accordance with generally accepted professional standards to treat an Illness or Injury;
3. Are determined to be:
    a. Rendered for the treatment or diagnosis of an Illness or Injury;
    b. Appropriate for the symptoms, consistent with the diagnosis;
    c. Otherwise in accordance with generally accepted medical practice and professionally recognized standards;
    d. Not mainly for the convenience of the Covered Person, his or her Doctor or other providers;
    e. Not in excess (in scope, duration or intensity) of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment;
    f. Not Experimental or Investigational;
    g. Services and supplies that are necessary for the therapeutic treatment of an Illness or Injury; and
4. When applied to confinement in a Hospital, the Covered Person:
    a. Must be confined as an Inpatient due to the nature of treatment, services or supplies rendered or due to his or her condition; and
    b. Cannot receive safe and adequate care through Outpatient treatment.

Treatment, services or supplies are not automatically deemed Medically Necessary based solely on the fact that they were prescribed, ordered or recommended by a Doctor or any other provider.

Medicare: The Health Insurance for the Aged Act. Title XVIII of the Social Security Amendments of 1965, as amended.

Mental Illness Disorder: Any nervous, emotional and/ or mental disease, Illness, syndrome, or dysfunction, other than a behavior or conduct disorders, classified in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* including, but not limited to neurosis, psychoneurosis, psychopathy, psychosis, and eating or panic disorder except for mental retardation. It also includes any nervous, emotional or nervous disorder that may be a manifestation of an organic condition, disease, Illness, or syndrome, including organic mental syndrome associated with psychoactive substances (e.g., alcohol, cocaine, opiate, and others).

Pathological Diagnosis: A Diagnosis of Life Threatening Cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Legally Qualified Physician who is a board-certified pathologist and whose Diagnosis of malignancy conforms to the standards set by the American College of Pathology.

Per Injury or Illness Deductible: The amount of Covered Benefits that a Covered Person must first incur for each Period of Treatment for each separate covered Injury or Illness. The Per Injury or Illness Deductible is shown on the Schedule of Benefits and must be satisfied before Covered Benefits under the Policy are paid. [If two or more Covered Persons in a family are injured in the same covered accident only one Per Injury or Illness Deductible must be satisfied for each Period of Treatment.]

Period of Treatment: For a covered Injury or Illness is a period which begins on the date a Covered Person: (1) is initially admitted to a Hospital, or (2) receives treatment in an Outpatient Surgical facility, or (3) receives Outpatient chemotherapy or radiation therapy for cancer treatment, and ends [180] consecutive days following that date for the same or related Injury or Illness. When a Period of Treatment ends a new Period of Treatment will apply to the same or related Injury or Illness. A separate Period of Treatment will apply to each covered Injury or Illness.

Per Injury or Illness Lifetime Maximum Benefit/Lifetime Maximum Benefit: The Maximum Benefit, as shown in the Schedule of Benefits, payable under the Policy for any one covered Injury or Illness for each Covered Person. When a Covered Person reaches the Per Injury or Illness Lifetime Maximum Benefit no further Benefits are payable for that Injury or Illness. When a Covered Person reaches the Lifetime Maximum Benefit for a Covered Benefit, as shown in the Schedule of Benefits, no further Benefits are payable for that Covered Benefit. No Benefits will be payable after the Covered Person's coverage under the Policy terminates.

Physical Therapy: The treatment of a covered Illness or Accidental Bodily Injury of a Covered Person by physical and mechanical means, such as massage, regulated exercise, water, light, heat, and electricity.

Policy: The contract providing the Benefits described herein issued to the Policyholder.

Policyholder: The entity, in whose name the Policy is issued, as specified in the Schedule of Benefits.

[Pregnancy: The period following the receipt by a Covered Person of a diagnosis of Pregnancy until the discharge of the Covered Person from the Hospital or other facility following the delivery of the newborn Child.]

Prescription Medication: Any medical substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a prescription and which is required to bear the following statement on the label: "Caution: Federal law prohibits dispensing without a prescription."

Preventive Care: Includes, but is not limited to, the following:

1. Periodic health evaluations, including tests and diagnostic procedures ordered in connection with a routine examination, such an annual physicals.
2. [Routine prenatal and well-child care.]
3. Child and adult immunizations.
4. Cancer screening services.

However, Preventive Care does not include any service intended to treat an Illness or Injury.

Pre-Existing Condition: A disease, Accidental Bodily Injury, Illness or physical condition for which a Covered Person:

1. Had treatment;
2. Incurred charge;
3. Took medication; or
4. Received a diagnosis or advice from a Doctor;

during the [12] month period immediately preceding the Covered Person(s) Coverage Effective Date.

Skilled Nursing Facility: A free-standing facility or part of a Hospital that is certified by Medicare to accept patients in need of rehabilitative and skilled care.

Spouse: The Eligible Person's lawful Spouse, common law Spouse, [domestic partner] [or] [domestic same sex partner] [under age [64 ½]].

Stroke: Any acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measureable objective neurological deficit persisting for at least 96 hours and expected to be permanent. The Diagnosis must be made by a Legally Qualified Physician board-certified as a Neurologist. A Stroke does NOT include Transient Ischemic Attack (mini-stroke), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits.

Substance Abuse: The pathological use or abuse of alcohol or other drugs or substances in a manner and to a degree that produces impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

Surgery/Surgical: A medical procedure or operation involving an incision with instruments, performed to repair damage, arrest disease in a living body or find out if disease is present.

Urgent Care Facility: A free-standing facility, by whatever actual name it may be called, which is engaged primarily in providing minor Emergency and episodic, medical care. A Doctor, a registered nurse and a registered X-ray technician must be in attendance at all times that the facility is open. The facility must include X-ray and laboratory equipment and a life support system. It must be licensed as an Urgent Care Facility, if required by law.

We, Our, Us, The Company: Madison National Life Insurance Company, Inc., a Wisconsin Insurance Company.

X-ray: A type or irradiation used for imaging purposes with the image captured on photographic film including those procedures in the CPT Code Range [80000] and those procedures in the CPT Code Range [90000] other than Advanced Studies; but excluding Preventive Care.

You, Your: An Eligible Person who is covered under the Policy.

Section 2

Eligibility and Effective Dates

All persons who:

1. Are members in good standing of the Association to which the Policy is issued; and
2. Are under age [64 ½] years;

are eligible to be insured as Eligible Persons under the Policy. [Evidence of Insurability acceptable to The Company may be required.]

Insurance for Eligible Persons will take effect at 12:01 A.M., local time at the Eligible Person's resident address on the Coverage Effective Date shown in the Schedule of Benefits if:

1. An application/enrollment form is completed and received by The Company on or before said Coverage Effective Date;
2. The underwriting rules of The Company are met; and
3. The first premium is received by The Company on or before the Coverage Effective Date.

A Dependent is eligible for coverage under the Policy upon meeting the definition of Dependent [and meeting [all] of the following requirements:]

(1) [The Dependent is insurable pursuant to Our then current underwriting guidelines; and]
(2) [The Eligible Person must be insured in order for his or her Dependents to be eligible for coverage.]

Insurance for Dependents will take effect on the date on which We approve the Eligible Person's written request for Dependent coverage and the applicable premium is paid.

Dependents Acquired After the Eligible Person's Coverage Effective Date

A newborn Child of an Eligible Person will become insured automatically on the day he or she is born as long as the Eligible Person's coverage is in force on that date. Coverage of the newborn Child includes prematurity, congenital defects and birth abnormalities. Coverage for the newborn Child will not continue past the 31-day period following birth unless:

1. The Company is notified by the end of that 31-day period of the Eligible Person's intent to add the newborn Child; and
2. Any applicable additional premium is paid.

An adopted Child or a Child placed for adoption who has not attained 18 years of age, will become insured automatically as of the date of adoption or placement for adoption. Placement for adoption means the assumption and retention by a person of the legal obligation for total or partial support of a child in anticipation of the Child's adoption. Coverage for an adopted Child or Child placed for adoption will not continue past the 31-day period following adoption or placement for adoption unless:

1. The Company is notified by the end of the 31-day period the Eligible Persons intent to add the Child; and
2. Any applicable additional premium is paid.

A Dependent spouse [or Domestic Partner] acquired after the Coverage Effective Date is eligible for coverage on the date of marriage to the Eligible Person [or the effective date of the Domestic Partnership]. Coverage begins on the first of the month next following Our receipt of the enrollment form or completion of the enrollment process and premium after the date of marriage [entering into the Domestic Partnership].

A Dependent Child acquired after the Coverage Effective Date is eligible for coverage on the date of marriage of the Eligible Person and Dependent Spouse [or the effective date of the Domestic Partnership]. Coverage begins on the first day of the month next following Our receipt of the enrollment form or completion of the enrollment process and premium after the date of marriage [or Domestic Partnership].

Section 3

Benefit Provisions

All Covered Benefits must be as a result of a non-occupational Illness or Injury while covered under the Policy. In addition all Covered Benefits must be Medically Necessary due to Injury or Illness [except Benefits under Preventive Care Indemnity Benefit Rider if such Rider is Included on the Schedule of Benefits].

Unless otherwise stated herein, all Benefits are subject to the Per Injury or Illness Deductible for each Period of Treatment, and are payable up to the Per Injury or Illness Lifetime Maximum Benefit.

[The following Benefits may be subject to specific Benefit maximums or limitations, as shown in the Schedule of Benefits. It is important that the Covered Person reviews the Schedule of Benefits for the Benefit's maximums or limitations.]

[Daily Hospital Room and Board (DRB) Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Daily Hospital Room and Board (DRB) Indemnity Benefit, as shown in the Schedule of Benefits, when a Covered Person has been admitted as an Inpatient in a Hospital. This DRB Benefit includes Inpatient accommodations and general nursing furnished by the Hospital. [This Benefit is not paid if Benefits are paid under the Daily Hospital Intensive Care Indemnity Benefit.]]

[Daily Hospital Intensive Care Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Daily Hospital Intensive Care Indemnity Benefit, as shown in the Schedule of Benefits, when a Covered Person has been admitted as an Inpatient in a Hospital Intensive Care Unit [or] [Cardiac Care Unit] [Burn Unit] [or] [Other Specialized Care Unit]. [This Benefit is paid in lieu of the Daily Hospital Room and Board Indemnity Benefit.]]

[Miscellaneous Hospital Services Inpatient Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Miscellaneous Hospital Services Inpatient Indemnity Benefit as shown in the Schedule of Benefits, when the Covered Person is an Inpatient in a Hospital. This Benefit includes Hospital Inpatient miscellaneous services and supplies, x-ray, laboratory and other diagnostic tests, and chemotherapy or radiation services for the treatment of cancer, services of a radiologist or radiology group and for services of a pathologist or pathology group for interpretation of diagnostic tests or studies necessary for the treatment of the Covered Person during while an Inpatient. This Benefit does not include fees charged for take home drugs, personal convenience items or items not intended primarily for the use of the Covered Person while an Inpatient.]

[Inpatient Surgeon Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Inpatient Surgeon Indemnity Benefit shown in the Schedule of Benefits, when a Covered Person has Inpatient Surgery.

If two Surgeries are performed through the same incision, then 100% of the Inpatient Surgeon Indemnity Benefit is paid on the first Surgery and 50% of the Inpatient Surgeon Indemnity Benefit is paid on the second Surgery and subsequent Surgeries. If two Surgeries are performed through different incisions, then 100% of the Inpatient Surgeon Indemnity Benefit is paid for each Surgery.

No Benefit will be paid for dentistry or oral surgery except:
1. Excision of impacted third molars;
2. Closed or open reduction of fractures or dislocation of the jaw.]

[Outpatient Surgeon Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Outpatient Surgeon Indemnity Benefit shown in the Schedule of Benefits, when a Covered Person has Outpatient Surgery.

If two Surgeries are performed through the same incision, then 100% of the Outpatient Surgeon Indemnity Benefit is paid on the first surgery and 50% of the Outpatient Surgeon Indemnity Benefit is paid on the second Surgery and subsequent Surgeries. If two Surgeries are performed through different incisions, then 100% of the Outpatient Surgeon Indemnity Benefit is paid for each Surgery.

No Benefit will be paid for dentistry or oral surgery except:
1. Excision of impacted third molars;
2. Closed or open reduction of fractures or dislocation of the jaw.]

[Outpatient Surgery Facility Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Outpatient Surgery Facility Indemnity Benefit shown in the Schedule of Benefits, when a Covered Person has Outpatient Surgery in an Outpatient Surgery facility. This Benefit includes services and supplies furnished by an Outpatient Surgery facility, such as: (a) use of an operating room and recovery room; (b) administration of drugs and medicines during surgery; (c) dressings, casts, splints; and (d) diagnostic services including radiology, laboratory, or pathology performed at time of surgery. [The Outpatient Surgery Facility Indemnity Benefit is not payable when Surgery is performed in a Doctor's office.]]

[Assistant Surgeon Inpatient Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Assistant Surgeon Inpatient Indemnity Benefit shown in the Schedule of Benefits, when a Covered Person has Inpatient Surgery by an assistant Surgeon or a licensed Surgical assistant who is performing duties within the scope of his/her license. [The Assistant Surgeon Inpatient Indemnity Benefit will equal [20%-50%] of the Benefit paid under the Inpatient Surgeon Indemnity Benefit.]]

[Assistant Surgeon Outpatient Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Assistant Surgeon Outpatient Indemnity Benefit shown in the Schedule of Benefits, when a Covered Person has Outpatient Surgery by an assistant Surgeon or a

licensed Surgical assistant who is performing duties within the scope of his/her license. [The Assistant Surgeon Outpatient Indemnity Benefit will equal [20%-50%] of the Benefit paid under the Outpatient Surgeon Indemnity Benefit.]]

[Anesthesiologist Inpatient Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Anesthesiologist Inpatient Indemnity Benefit shown in the Schedule of Benefits when a Covered Person has Inpatient Surgery and receives anesthesia. [The Anesthesiologist Inpatient Indemnity Benefit will equal [20%-50%] of the Benefit paid under the Inpatient Surgeon Indemnity Benefit.]]

[Anesthesiologist Outpatient Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Anesthesiologist Outpatient Indemnity Benefit shown in the Schedule of Benefits when a Covered Person has Outpatient Surgery and receives anesthesia. [The Anesthesiologist Outpatient Indemnity Benefit will equal [20%-50%] of the Benefit paid under the Outpatient Surgeon Indemnity Benefit.]]

[Doctor Visit while Hospital Confined Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Doctor Visit while Hospital Confined Indemnity Benefit shown in the Schedule of Benefits when a Covered Person is Hospital confined and is visited by a Doctor, other than a Surgeon. [This Benefit will equal [10%-25%] of the DRB Indemnity Benefit for each Inpatient visit.] [This Benefit is limited to [1] Inpatient Doctor visit per day.]]

[Second Surgical Opinion Office Visit Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Second Surgical Opinion Office Visit Indemnity Benefit shown in the Schedule of Benefits, when the Covered Person obtains a Surgical opinion from another Doctor prior to the Surgical procedure. If the second Surgical opinion disagrees with the first Surgical opinion, a Benefit for a third second Surgical Opinion Office Visit will be paid. This Benefit is [$50-$200] [and is] payable for a second and third Surgical Opinion Office Visit. This Benefit is only payable provided the Doctors providing the second and third Surgical opinions:

1. are not affiliated with each other or with the original Doctor who will perform the Surgery,
2. are not financially associated with the original Doctor; and
3. do not assist in the Surgery.

[This Benefit is not subject to the Per Injury or Illness Deductible.]

[Ambulance Transport Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Ambulance Transport Indemnity Benefit shown in the Schedule of Benefits, when a Covered Person has a conveyance in an ambulance that is Medically Necessary to transport a Covered Person to the nearest Hospital or facility qualified to render treatment and is provided on an Emergency basis.

[The Benefit is [$250-$500] per Covered Person per conveyance for [air] [water] [and] [ground] ambulance transportation.]]

[Outpatient Physical, Speech and Occupational Therapy Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Outpatient Physical, Speech and Occupational Therapy Indemnity Benefit shown in the Schedule of Benefits, when a Covered Person receives outpatient therapy

[within [15-30] days] following an Inpatient confinement or Outpatient Surgery.] [The Benefit is [$25-$75] per therapy treatment and is limited to [15-30] treatments for any one type of therapy, and up to [45-60] treatments combined for any combination of therapies.]]

[Continued Care Indemnity Benefit
(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Continued Care Indemnity Benefit shown in the Schedule of Benefits when the Covered Person needs continued skilled care [within [15-30] days following an Inpatient confinement]. [The Continued Care Indemnity Benefit is limited to the following maximum Benefit per Injury or Illness:

[Skilled Nursing Care: up to [$50-$200] per day, and up to [30-75] days]
[Private Duty Nursing Care: up to [$50-$200] per shift, and up to [20-50] eight-hour shifts]
[Home Health Care: up to [$50-$200] per visit, and up to [60-90] visits]
[Hospice Care Services: [$1,000-$3,000] Lifetime Maximum Benefit; this Benefit is paid once while the Covered Person is covered under the Policy]]]

[Outpatient Chemotherapy and Radiation Therapy for Cancer Treatment Daily Indemnity Benefit *(Applicable only if this Benefit is included on the Schedule of Benefits.)*

The Company will pay the Outpatient Chemotherapy and Radiation Therapy for Cancer Treatment Daily Indemnity Benefit shown in the Schedule of Benefits, when the Covered Person receives Outpatient chemotherapy, including chemotherapy medication and radiation therapy for the treatment of cancer. [The Benefit is [[1-3] times the DRB Indemnity Benefit] [[$200-$3,000] per treatment, up to a Lifetime Maximum Benefit of [50-200] treatments.]]

[Critical Illness Deductible Waiver
(Applicable only if this Benefit is included on the Schedule of Benefits.)

If [an Eligible] [a Covered] Person is diagnosed with a Critical Illness following [a 6-month Benefit waiting period after] the [Eligible] [Covered] Person's Effective Date of Coverage We will waive [50%-100%] of the Per Injury or Illness Deductible for the initial Period of Treatment. [This Benefit is [subject to a [6]-month Benefit waiting period] and is limited to one Per Injury or Illness Deductible waiver during the [Eligible] [Covered] lifetime while covered under the Policy.]]

Section 4

Exclusions and Limitations

The Policy does not provide any Benefits when a Covered Person has any of the following:

1. [A Pre-existing Condition(s); or]
2. Preventive Care, including routine physical examinations, and immunizations [except as specified in the Preventive Care Indemnity Benefit Rider, if shown as Included in the Schedule of Benefits]; or
3. Any treatment, service or supply which is not due to an Illness or Injury; or
4. Any treatment, service or supply which is not recommended by a Doctor; or
5. Any treatment, service or supply which is not Medically Necessary; or
6. Treatment, services or supplies for which no charge is made or for which the Covered Person is not required to pay; or
7. Any treatment, service or supply provided by a government owned or operated facility or by government employed health care providers; or
8. A weekend Hospital Confinement occurring between noon on any Friday and noon the following Sunday for non-emergency procedures, unless Medically Necessary or unless surgery is scheduled for the next day; or
9. An Illness or Injury which arises out of or in the course of any employment for wage or profit or an Illness or Injury for which the Covered Person has or had a right to recovery under any Workers' Compensation or Occupational Disease Law; or
10. Physical or psychological examinations required by any third party, such as by a court or for employment, licensing, insurance, school, sports or recreational purposes; or
11. An Illness or Injury incurred while on active duty with the military of any country or international organization; or
12. An Illness or Injury resulting from war or any act of war (declared or undeclared) or the participation in a riot or insurrection; or
13. An Illness or Injury incurred (a) during the commission or attempted commission of a crime or felony or while engaged in an illegal act; or (b) while imprisoned; or
14. An Illness or Injury, incurred due to, or contracted as a consequence of a Covered Person (a) being intoxicated; or (b) being under the influence of any illegal narcotic, barbiturate, hallucinatory or other drug, unless administered by a Doctor and taken in accordance with the prescribed dosage. A Covered Person is conclusively determined to be intoxicated by drug or alcohol if a chemical test administered in the jurisdiction where the loss or cause of loss occurred is at or above the legal limit set by that jurisdiction; or
15. An Illness or Injury for which treatment, services or supplies were received or purchased outside the United States unless the charges are incurred while traveling on business or for pleasure, for a period not to exceed [30-90] days, and the charges are incurred for an Emergency, provided the treatment, services or supplies used in connection with the Emergency are approved for use in the United States; or
16. Treatment, services or supplies to improve the appearance or self-perception of a Covered Person, which does not restore a bodily function including, without limitation, cosmetic or plastic surgery, hair loss or skin wrinkling, or the complications of any such treatment; or
17. Treatment, services or supplies for (a) breast augmentation; (b) the removal of breast implants unless Medically Necessary and related to surgery performed as reconstructive surgery due to and Illness; and (c) breast reduction surgery unless Medically Necessary due to an Illness; or
18. Surgery to correct refractive errors, such as radial keratotomy or radial keratectomy; or
19. Routine eye exams, glasses, visual therapy, or contact lenses; or
20. Routine hearing exams to assess the need for, or change to, hearing aids; and the purchase, fittings or adjustments of hearing aids; or
21. Penile implants and fertility and sterility studies; or
22. Treatment, services or supplies: (a) to restore or enhance fertility; or (b) to reverse sterilization; or

23. Impregnation techniques such as: (a) artificial insemination; or (b) in vitro fertilization; including but not limited to: artificial insemination, in vitro zygote and intra-fallopian transfers, gamete intra-fallopian transfer, and genetic counseling; or
24. Voluntary abortion, except if the life of the mother would be in danger if the fetus were carried to term; or
25. Mental Illness Disorders; or
26. Substance Abuse; or
27. Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco, including but not limited to: nicotine withdrawal programs; nicotine products, such as transdermal patches and gums; hypnotism; and goal oriented behavioral modification; or
28. Marriage or family counseling, recreational therapy, equine therapy, educational therapy, social therapy, or sex therapy; or
29. Sexual reassignments or sexual dysfunctions or inadequacies; or
30. Meridian therapy (acupuncture), or spinal manipulation; or
31. Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails (other than partial or complete removal of nail roots); or
32. Treatment, services or supplies related to the feet by means of posting or strapping, or range of motion studies; or
33. Orthotics; or
34. Treatment, services or supplies for obesity or weight reduction, including wiring of the teeth and all forms of intestinal bypass surgery and complications resulting from such surgery; or
35. Treatment, services or supplies received from a Doctor or other provider if such person is: (a) a person who ordinarily resides in Your household, (b) a member of Your Immediate Family; or
36. Custodial care, domiciliary care or rest cures regardless of who prescribes or renders such care; or
37. An Illness or Injury resulting from participation in hazardous avocations including: mountain or rock climbing, sky diving, hang gliding, motor vehicle racing, scuba diving, rodeo or private aviation; or
38. Telephone consultations, missed appointment fees and fees for completing claim forms; or
39. Treatment, services or supplies for complications of conditions that are not covered under the Policy; or
40. Outpatient Prescription Medications, [except as specified in the Outpatient Prescription Medication Indemnity Benefit Rider, if shown as Included in the Schedule of Benefits;] or
41. Treatment, services or supplies related to: (a) the teeth; and (b) the gums other than tumors; and (c) any other associated structures; (d) the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids; and (e) dental implants, regardless of the cause; or
42. Treatment, services or supplies as the result of prognathism, retrognathism, microtrognathism, or any treatment, services or supplies to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible, unless due to an Injury to sound natural teeth which occurs while the Covered Person is covered under the Policy and provided such treatment is received within 12 months following the date of the Injury, or is to correct growth defects after one year from the date of birth of a Covered Dependent Child; or
43. Treatment, services or supplies provided for temporomandibular joint (TMJ) dysfunction; or
44. Speech and occupational therapy [expect as specified in the Outpatient Physical, Speech, and Occupational Therapy Indemnity Benefit, if shown as Included in the Schedule of Benefits]; or
45. Hospice Care [expect as specified in the Continued Care Indemnity Benefit, if shown as Included in the Schedule of Benefits]; or
46. Home Health Care [expect as specified in the Continued Care Indemnity Benefit, if shown as Included in the Schedule of Benefits]; or
47. Experimental or Investigational procedures, drugs or treatment methods; or
48. Experimental or Investigational organ transplant procedures; or
49. Pregnancy and related services and routine newborn care; or
50. Intentional self-inflicted Illness or Injury while sane; except that this exclusion will not apply to any self-inflicted Illness or Injury that is the result of a medical condition; or
51. Physical Therapy; [except as specified in the Outpatient Physical, Speech, and Occupational Therapy Indemnity Benefit, if shown as Included in the Schedule of Benefits]; or

52. Inpatient personal convenience items including, but not limited to, beauty or barber services, radio and television, massages, telephone charges, take home drugs and supplies, guest meals, and motel accommodations; or
53. Outpatient treatment, services and supplies except as specifically provided for in the Policy as specified in Section 3 – Benefits and as shown on the Schedule of Benefits.

[Limitations and Exclusions for Pre-Existing Conditions

Benefits shall not be payable for a Pre-Existing Condition as defined herein. This provision will cease to apply to any Covered Benefits incurred in connection with a Pre-Existing Condition after the Covered Person has been continuously covered under the Policy for [1-12] consecutive months.

This provision does not apply to a newborn or newly adopted Child or Child placed for adoption under the age of 18 if such Child is enrolled for coverage within 31 days from the date of birth or the date of adoption or placement for adoption.]

Section 5

Termination of Insurance

Termination of an Eligible Person's Coverage

Coverage for an Eligible Person shall automatically terminate on the earliest of the following dates:
1. The date of termination of the Policy; or
2. The last day of the month in which You are no longer a member of the Policyholder; or
3. [The last day of the month following the date You attain age [65]; or]
4. [The last day of the month You become eligible for Medicare; or]
5. The date You fail to pay the required premium; or
6. The premium due date coinciding with or next following the date after We receive Your written request to terminate Your coverage under the Policy; or
7. The date You enter the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less or as provided under the Statement of Uniform Services Employment and Reemployment Rights Act of 1994 provision; or
8. The date of Your death.

Termination of a Dependent's Coverage

Coverage for Your Dependents shall terminate on the earliest of the following dates:
1. The date of termination of the Policy; or
2. The date You fail to pay the required premium; or
3. The premium due date coinciding with or next following the date after We receive Your written request to terminate Your Dependent's coverage; or
4. The date the Dependent enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less or as provided under the Uniform Services Employment and Reemployment Rights Act of 1994; or
5. [With respect to Your covered Dependent Spouse, the last day of the month following the date Your spouse attains age [65]; or]
6. [With respect to Your covered Dependent Spouse, the last day of the month Your spouse becomes eligible for Medicare; or]
7. With respect to Your covered Dependent Spouse, the premium due date coinciding with or next following the date on which the Eligible Person is divorced or legally separated from such spouse; or
8. [The date Your coverage under the Policy is terminated; or]
9. With respect to Your covered Dependent Child, the premium due date coinciding with or next following the earliest of:
    - The date of the covered Dependent Child's marriage;

- The date the Covered Dependent Child attains [age 26] [age [19] or age [26] if the unmarried Child is dependent upon You for support and maintenance].

If a covered unmarried Dependent Child's coverage terminates upon attaining any limiting and such Dependent Child is incapable of earning his or her own living and is chiefly Dependent upon the Covered Person for support and maintenance, because of Mental or Physical Incapacity, as defined below, coverage for the Dependent Child may be continued during the continuance of such incapacity, providing that:

a. Medical proof, in writing, of such incapacity must be given to Us within 31 days after the date on which the Dependent Child attains a limiting age;
b. We shall have the right any time during the continuance of insurance under this provision to require due proof of the continuance of the incapacity and to have the Dependent Child examined by Doctors designated by Us at any time during the first 2 years of such continuance and not more than once each year thereafter;
c. You continue paying the required premium for the Dependent; and
d. The continuance described herein shall cease in the event of the occurrence of any of the circumstances described in the Termination of Dependent's Coverage above.

For the purposes of the provision, Mental or Physical Incapacity means a mental or physical impairment that results in anatomical, physiological or psychological abnormalities which are demonstrated by medically acceptable clinical, laboratory or diagnostic techniques and which are expected to last for a continuous period of time not less than 12 months in duration.

Section 6

Premiums

All premiums are payable on or before the date they are due. Premiums are payable by a mode of payment that has been selected by the Eligible Person.

The premium rates may be changed by The Company. If the rates are changed, The Company will give at least 31 days advance written notice. If an increase takes place on other than a premium due date, they will be due on the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be discontinued as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

If a change in Benefits increases The Company's liability, premium rates may be changed on the date that the liability is increased.

The Company will promptly refund any unearned premium upon notification of the death of any Covered Person under this Policy. The refund of premiums will be made directly to:
1. The decedent's Spouse at the time of the decedent's death;
2. The Eligible Person, if the decedent was a covered Dependent Child; or
3. The decedent's estate, if neither (1) or (2) applies.

Grace Period
A grace period of 31 days is allowed for payment of each premium (except the first) during which coverage under the Policy shall remain in force. Coverage may terminate prior to the end of the grace period by giving Us at least 31 days advance written notice of cancellation. Failure to pay a premium within the grace period will cause coverage under the Policy to lapse as of the date for which the last premium payment has been made.

[Section 7

Pre-certification of Care Program

Pre-certification is required prior to each Inpatient confinement for an Injury or Illness. [Pre-certification is also required prior to receiving Outpatient chemotherapy or radiation treatment.]

If the Covered Person does not comply with the Pre-certification requirements, [Benefits are subject to the Pre-certification penalty amount shown in the Schedule of Benefits] [no Benefits will be paid for that confinement or treatment.] [The Pre-certification penalty amount is in addition to the Per Injury or Illness Deductible.]

To request Pre-certification, the Covered Person or the Covered Person's attending Physician must contact the designated Pre-certification service at least [7] days prior to each non-Emergency Inpatient Confinement [or receiving Outpatient chemotherapy or radiation treatment]. Emergency Inpatient confinements must be Pre-certified within [48] hours following the admission, or as soon as reasonably possible. The Pre-certification service may be reached by writing or by telephone during normal business hours each business day. The name of the designated Pre-certification service and instructions for requesting Pre-certification is provided to each Eligible Person.

The Pre-certification service will then consult with the Covered Person's attending Physician. If the Pre-certification service concurs with the Covered Person's attending Physician with the appropriateness of the setting and Medical Necessity of the proposed treatment plan, the Pre-certification service will notify the Covered Person in writing and the Covered Person will be deemed to have complied with the Pre-certification requirement described herein.

The Pre-certification service may also conduct a continued stay review for any ongoing Inpatient Confinement. The continued stay review is a process of monitoring a Covered Person's progress on a daily basis to determine if the Covered Person will be discharged within the Pre-certified number of days and to determine the appropriate number of additional days of Inpatient confinement that may be required according to the Covered Person's condition and plan of treatment. Inpatient confinements will be monitored to assure that the Covered Person will be discharged timely. The attending Physician and the facility's utilization review nurses will be contacted to determine the progress of the Covered Person and the need, if any, for an extension of the length of stay of the Inpatient confinement. If an extension of the Inpatient confinement is not Pre-certified for all or part of the requested day(s), the Covered Person and the attending Physician will be notified.

Benefits are not paid for days of Inpatient confinement which extends beyond the number of days deemed by the Pre-certification service to be Medically Necessary.

If the Pre-certification service does not concur with the Covered Person's Physician, the Pre-certification service will so notify the Insured Person in writing and the Covered Person will be deemed as not in compliance with the Pre-certification requirement described herein.

PRE-CERTIFICATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT OF BENEFITS WILL BE DETERMINED IN ACCORDANCE WITH AND SUBJECT TO ALL THE TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THE POLICY.

For the purposes of this Section Pre-certification/Pre-Certify means a screening process using established medical criteria to determine if the proposed Inpatient confinement [or proposed Outpatient chemotherapy or radiation treatment] is Medically Necessary and appropriate for the treatment of a covered Injury or Illness. Pre-certification is not pre-authorization or pre-approval of coverage and does not guarantee payment of Benefits.]

Section [8]

General Provisions

Entire Contract
The entire contract is made up of: (a) the Policy; (b) the Policyholder application; and (c) any individual Eligible Person applications. No agent, Covered Person, or other individual, except Our President, Vice President, Secretary or Assistant Secretary can: (a) approve a change to the Policy; or (b) extend the time for payment of any premium. No change will be valid unless it is made: (a) by an Endorsement or Rider to the Policy; or (b) by an Amendment signed by Our President, Vice President, Secretary or Assistant Secretary. Any change made will be binding on each Covered Person and on any other individual(s) referred to in the Policy.

Contestability
In the absence of fraud, statements made by any Covered Person or the Policyholder are representations and not warranties. After a Covered Person has been covered under the Policy for 2 consecutive years, only fraudulent misstatements in the application may be used to void a Covered Person's coverage under the Policy or deny any claim for loss incurred or disability starting after the 2-year period. If a Covered Person's age was misstated, We will provide the amount of insurance for the correct age and an equitable premium adjustment will be made so that We will receive the correct premium for the true age.

Notice of Claim
Written notice of claim must be given to Us: (a) within 20 days after the date on which the claim was incurred; or (b) as soon as reasonably possible thereafter. Notice can be sent to Our authorized administrator or Our Home Office. The notice should include the Covered Person's name and policy number.

Assignments
An Eligible Person may authorize Us or Our authorized administrator to pay Benefits directly to a Doctor or other health care provider from whom he or she receives services.

Proof of Loss
Written proof of loss must be given to Us or Our authorized administrator within 90 days of the date on which the claim was incurred. If it was not possible for proof to be given within the 90 days, We will not deny the Benefit provided proof is given as soon as reasonably possible. The date on which the claim was incurred is the date on which the services or supplies were provided. Notwithstanding the forgoing, proof must be sent no later than one year from the date on which the claim was incurred unless the Eligible Person is legally incapacitated.

Time of Payment of Claims
Benefits will be paid subject to written proof of loss. Any balance unpaid at the end of liability will be paid on receipt of written proof of loss. Benefits paid under the Policy will be paid within 30 days following the date on which Our authorized administrator receives written proof of loss. Claims payable under the Policy are overdue if not paid within 30 days after We, or Our authorized administrator, receive proof of loss and necessary medical information or other information required by Us essential to administer the provisions of the Policy. If such information is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within 30 days. Any part or all of the remainder of the claim that is later supported by such proof is overdue if not paid within 30 days.

Payment of Claims
Benefits will be payable to the Eligible Person [unless they are assigned to a Doctor or other health care provider.] Any notice of assignment of Benefits must be in writing and mailed to Us or Our authorized administrator. Notice of the assignment of Benefits received from a Doctor or

other health care provider will be sufficient to cause Benefits to be paid to such Doctor, Hospital or other health care provider. You may revoke an assignment of Benefits at any time by providing written notice of such revocation to Us or Our authorized administrator. Any such written revocation of an assignment of Benefits shall be valid as to both You and the Doctor, Hospital or other health care provider.

Recovery of Overpayments
We reserve the right to deduct from any Benefits properly payable under this Policy the amount of any payment that has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss;
3. Pursuant to fraud or intentional misrepresentation made to obtain coverage under the Policy in the event that a loss related to the fraud or intentional misrepresentation is incurred within 2 years after the date such coverage commences;
4. With respect to an ineligible person; or
5. Pursuant to a claim for which Benefits are recoverable under any Policy or act of law providing coverage for occupational Injury or disease to the extent that such Benefits are recovered.

Such deduction may be against any claim for Benefits under the Policy made by a Covered Person if claim payments under this reservation of rights were made with respect to such Covered Person.

Conformity with Federal and State Laws
Any provision of the Policy which is in conflict with federal laws or any applicable state law, is hereby amended to meet the minimum requirements of the law.

Legal Actions
No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Clerical Errors
Clerical error pertaining to the coverage of any Covered Person shall not terminate coverage otherwise validly in force nor continue coverage otherwise validly terminated. If a clerical error occurs, We or Our authorized administrator, reserves the right to make any corresponding premium adjustment which will be computed on the basis of the premium rates then in effect.

Reformation of Coverage:
If We or Our authorized administrator determine that there was a material misrepresentation or omission in the application for coverage that caused Us to issue coverage without a specific condition Amendatory Exclusion Endorsement or premium rate adjustment that would have been included had there been no material misrepresentation or omission, We may reform Your insurance coverage by (1) issuing such Amendatory Exclusion Endorsement and requiring that You execute it in order to maintain the Covered Person's coverage; or (2) adding a premium adjustment to Your coverage and requiring that You pay the additional premium retroactively to the Coverage Effective Date of the Covered Person's coverage under the Policy. Once executed, the Amendatory Exclusion Endorsement will apply to Your coverage beginning on the Coverage Effective Date of the Covered Person's coverage under the Policy. Once the Amendatory Exclusion Endorsement is applicable to Your coverage, We may request a refund of Benefits paid which would not have been paid under the Amendatory Exclusion Endorsement. If You do not accept the proposed Amendatory Exclusion Endorsement or remit the adjusted additional premium, We may rescind the Covered Person's coverage.

Rescission of Coverage
If We or Our authorized administrator determine that there was a material misrepresentation or omission in the application for coverage that caused Us to issue coverage when coverage would not have been issued had there been no material misrepresentation or omission, We may rescind coverage. If the material misrepresentation or omission pertained to the Eligible Person,

coverage may be rescinded for the Eligible Person and all Covered Dependents. If the material misrepresentation or omission pertained to a Covered Dependent, coverage may be rescinded for that Dependent. Rescission causes coverage to be terminated back to the Coverage Effective Date as if the coverage was never issued.

Rescission will result in the denial of Benefits. If rescission occurs, We will refund premiums received for any coverage We rescind within a reasonable time of the rescission, however, We will subtract total Benefit payments for the person whose coverage We rescinded from this premium refund. If We have paid Benefits in excess of the amount of premium We received for the person whose coverage We rescinded, We have the right to obtain a refund from the Eligible Person.

Waiver of Rights
If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date; nor will it affect Our right to enforce any other provision of the Policy. Any waiver of rights must be in writing and signed by Our President, Vice President Secretary or Assistant Secretary or an individual authorized by them to agree to such waiver.

Required Information
The Eligible Person agrees to provide to Us any information or data that We reasonably request for the proper administration of the Policy including; but not limited to, information pertaining to medical history, medical records, the names of all health care providers from whom Covered Persons have received treatment or services, marriage license, documentation of adoption or placement for adoption, documentation of legal custody of a Dependent, student status information, and treating provider statements.

Effective Date
No insurance under the Policy shall become effective until notice in writing is given by Us or Our authorized administrator. Issuance of a Certificate with a Schedule of Benefits will be deemed proper notification, provided premium due has been paid in accordance with the terms of the Policy.

[Subrogation/Right Of Reimbursement
As a condition to receiving Benefits under the Policy, Covered Person(s) agree to transfer to Us their right to recover damages to the extent of Benefits paid by Us when an Illness or Injury occurs through the act or omission of another person. If a Covered Person received payment from another person or entity on account of, due to, or arising out of an Illness or Injury, the Covered Person agrees to reimburse Us to the full extent of the amount paid by Us. If a repayment agreement is required to be signed, all rights of recovery are transferred to Us regardless of whether it is actually signed. It is only necessary that the Illness or Injury occur through the act or omission of another person or entity. Our rights of full recovery may be from any other person or entity, any liability or other insurance covering such other person or entity party, the Covered Person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault, workers compensation or school insurance Coverages which are paid or payable. We may enforce Our reimbursement rights by requiring the Covered Person to assert a claim to any of the foregoing Coverages to which the Covered Person may be entitled. Covered Person(s) shall provide all requested accident and insurance information to Us. We shall not be required to pay any portion of Covered Person's attorneys' fees or other costs associated with a claim/lawsuit.]

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

[OPTIONAL] EMERGENCY ROOM INDEMNITY BENEFIT RIDER

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

The Benefits provided by this Rider will not duplicate the Benefits provided under the Certificate and any other Rider and are subject to the maximum Benefit amount shown on the Schedule of Benefits. [The Per Injury or Illness Deductible does not apply to this Benefit.]

A. BENEFITS

When You are covered under the Emergency Room Indemnity Benefit Rider, and as shown as Included on the Schedule of Benefits, the Emergency Room Indemnity Benefit, as shown on the Schedule of Benefits, will be paid when a Covered Person receives Emergency treatment in an Emergency Room for a covered Injury or Illness. Benefits are payable up to the Calendar Year Maximum Benefit as shown on the Schedule of Benefits.

B. DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein.

C. TERMINATION

Coverage under this Rider will end on [the earliest of:]

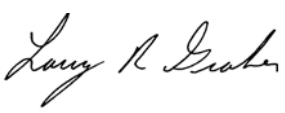
1. the date coverage under the Policy ends[; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made a part of the Policy/Certificate as of [its Effective Date] [August 1, 2010] [or] [Your Coverage Effective Date] [whichever is later].

This Rider is subject to all provisions of the Policy which are not in conflict with the terms of this Rider. Nothing in this Rider will be held to vary, alter, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President

Adam C. Vandervoort
Secretary

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

[OPTIONAL] INPATIENT CONFINEMENT ENHANCEMENT INDEMNITY BENEFIT RIDER

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

The Benefits provided by this Rider will not duplicate the Benefits provided under the Certificate and any other Rider and are subject to the maximum Benefit amount shown on the Schedule of Benefits. [The Per Injury or Illness Deductible applies to this Benefit and must be satisfied before Benefits are paid under this Rider.].

A. BENEFITS

When You are covered under the Inpatient Confinement Enhancement Indemnity Benefit Rider, and as shown as Included on the Schedule of Benefits, Covered Benefits payable for the Daily Hospital Room and Board Indemnity Benefit, the Daily Hospital Intensive Care Indemnity Benefit and the Miscellaneous Hospital Services Inpatient Indemnity Benefit will be increased to the amount shown on the Schedule of Benefits, after the Covered Person's Inpatient confinement during a Period of Treatment, for the same covered Illness or Injury, exceeds the number of days as shown on the Schedule of Benefits. The increased Benefits payable under this Rider are paid retroactively beginning with the first day of the Covered Person's Inpatient confinement and are payable for each Inpatient day related to the same covered Injury or Illness during the same Period of Treatment.

B. DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein.

C. TERMINATION

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends[; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made a part of the Policy/Certificate as of [its Effective Date] [August 1, 2010] [or] [Your Coverage Effective Date] [whichever is later].

This Rider is subject to all provisions of the Policy which are not in conflict with the terms of this Rider. Nothing in this Rider will be held to vary, alter, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Larry R. Graber
President

Adam C. Vandervoort
Secretary

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

[OPTIONAL] PREVENTIVE CARE INDEMNITY BENEFIT RIDER

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

The Benefits provided by this Rider will not duplicate the Benefits provided under the Certificate and any other Rider [and are subject to the maximum Benefit amount shown on the Schedule of Benefits].

When You are covered under the Preventive Care Indemnity Benefit Rider, and as shown as Included on the Schedule of Benefits, We will pay the following Preventive Care Benefits [after the Covered Person has been covered under this Preventive Care Indemnity Benefit Rider as specified on the Schedule of Benefits]. [The Per Injury or Illness Deductible does not apply to this Benefit.]

A. PREVENTIVE CARE INDEMNITY BENEFITS

Benefits are payable under this Rider when a Covered Person receives the following Preventive Care services:

a. one routine physical examination of the heart, lungs and abdomen by a Doctor per Calendar Year;
b. diagnostic tests that are performed during the routine physical examination or in conjunction with the routine physical examination;
c. annual screening mammogram in accordance with the age recommendations and most current American Cancer Society breast cancer screening guidelines;
d. one routine cervical smear or pap smear per Calendar Year;
e. one prostate cancer screening known as Prostate Specific Antigen (PSA) per Calendar Year, in accordance with the age recommendations and most current American Cancer Society prostate cancer screening guidelines;
f. colorectal cancer screening and laboratory tests in accordance with the age recommendations and most current American Cancer Society colorectal cancer screening guidelines; [and]
g. immunizations in accordance with the recommendations of the Department of Health and Human Services Centers for Disease Control and Prevention; [and]
h. [routine prenatal and well child care]

B. DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein.

C. TERMINATION

Coverage under this Rider will end on [the earliest of:]

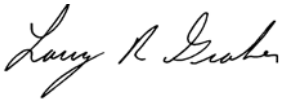
1. the date coverage under the Policy ends[; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made a part of the Policy/Certificate as of [its Effective Date] [August 1, 2010] [or] [Your Coverage Effective Date] [whichever is later].

This Rider is subject to all provisions of the Policy which are not in conflict with the terms of this Rider. Nothing in this Rider will be held to vary, alter, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
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Adam C. Vandervoort
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MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

[OPTIONAL] OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT RIDER

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

The Benefits provided by this Rider will not duplicate the Benefits provided under the Certificate and any other Rider and are subject to the maximum Benefit amount shown on the Schedule of Benefits. [The Per Injury or Illness Deductible does not apply to this Benefit.]

A. BENEFITS

When You are covered under the Outpatient Physician Office Visit Indemnity Benefit Rider, and as shown as Included on the Schedule of Benefits, the Physician Office Visit Indemnity Benefit, as shown on the Schedule of Benefits, will be paid for Physician Office Visits up to the Calendar Year Maximum Benefit as shown on the Schedule of Benefits.

B. DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to this Physician Office Visit Indemnity Benefit Rider. When used in this Rider these terms are capitalized:

Physician Office Visit: A visit with a Physician due to a covered Injury or Illness, which occurs in a Physician's office. Physician Office Visit does not include Physician visits elsewhere, including, but not limited to, visits made in an Ambulatory Surgical Center, Skilled Nursing Facility, Hospital, Hospice, or in a place of residence.

C. TERMINATION

Coverage under this Rider will end on [the earliest of:]

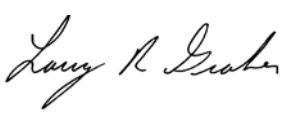
1. the date coverage under the Policy ends[; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made a part of the Policy/Certificate as of [its Effective Date] [August 1, 2010] [or] [Your Coverage Effective Date] [whichever is later].

This Rider is subject to all provisions of the Policy which are not in conflict with the terms of this Rider. Nothing in this Rider will be held to vary, alter, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President

Adam C. Vandervoort
Secretary

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[**P.O. Box 5008, Madison, WI 53705**]

[OPTIONAL] OUTPATIENT PRESCRIPTION MEDICATION INDEMNITY BENEFIT RIDER

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

The Benefits provided by this Rider will not duplicate the Benefits provided under the Certificate and any other Rider [and are subject to the maximum Benefit amount shown on the Schedule of Benefits].

A. OUTPATIENT PRESCRIPTION MEDICATIONS
When You are covered under the Outpatient Prescription Medication Indemnity Benefit Rider, and as shown as Included on the Schedule of Benefits, Benefits for covered Prescription Medications provided to a Covered Person will be paid [subject to the separate [Outpatient Prescription Medication Calendar Year Deductible] as shown on the Schedule of Benefits. [The Per Injury or Illness Deductible does not apply to this Benefit.]

B. OUTPATIENT PRESCRIPTION MEDICATIONS BENEFIT
Covered Benefits under this Rider must be:

1. Approved by the United States Federal Drug Administration (FDA); and
2. Lawfully obtained only upon the written prescription of a Physician; and
3. Prescribed by a Physician to treat a covered Injury or Illness; and
4. Obtained from a licensed pharmacist.

Covered Benefits include hormone replacement therapy when prescribed or ordered for treating symptoms and conditions of menopause.

Covered Benefits also include Outpatient contraceptive drugs.

Benefits may vary by the type of Prescription Medication being dispensed:
- Generic Medication
- [Formulary Brand Drugs]
- [Non-Formulary Brand Drugs]
- [Specialty Medications]

[C. PHARMACY BENEFIT MANAGER
A Pharmacy Benefit Manager (PBM) administers Your Benefits under the Outpatient Prescription Medication Benefit Indemnity Rider. The PBM has contracted with retail pharmacies across the United States to dispense Outpatient Prescription Medications at negotiated discounted rates. A pharmacy contracted with the PBM is an In-Network Pharmacy.

1. If the dispensing Pharmacy is an In-Network Pharmacy, the Covered Person must show his or her identification card to the Pharmacist (or where applicable, to the Physician). The amount of the Prescription Medication charged by the Pharmacy will be reduced by the Benefit amount shown in the Schedule of Benefits based on the type of prescription being dispensed and after the Covered Person has satisfied any applicable Outpatient Prescription Medication Calendar Year Deductible. If the cost of the Prescription Medication is greater than the Prescription Medication Benefit amount shown on the Schedule of Benefits, the Covered Person is responsible for the difference between the cost of the Prescription Medication and the Benefit amount. If the cost of the Medication is less than the Benefit amount shown on the Schedule of Benefits, then the Covered Person can complete a direct reimbursement claim form to receive payment of the remaining balance. The direct reimbursement claim form is available from the PBM upon request. The completed claim form can be submitted to the PBM at address as indicated on the back of the Covered Person's identification card.

2. If the dispensing Pharmacy is an Out-of-Network Pharmacy, or if the Covered Person uses an In-Network Pharmacy but elects not use his or her identification card, the Covered Person is responsible for paying the Pharmacy for the amount of the Prescription Medication. The Covered Person can complete a direct reimbursement claim form, which is available from the PBM upon request, and submit it to the address as

indicated on the back of the Covered Person's identification card. The Covered Person will be paid the Benefit amount as shown on the Schedule of Benefits [less the Covered Person's Outpatient Prescription Medication Calendar Year Deductible].]

C. EXCLUSIONS

The following Outpatient Prescription Medications and supplies will not be considered Covered Benefits under this Outpatient Prescription Medication Indemnity Rider and no Benefit payments will be made for such purchases:

1. Contraceptive devices, including injectible medications, implantable or intradermal patch contraceptives; or
2. Over-the-Counter medications, supplies or products; or
3. Medications or other agents to increase or enhance fertility or the likelihood of conception; or
4. Medications for the treatment of erectile dysfunction or to assist in or enhance sexual performance; or
5. Vitamins; or
6. Medications to eliminate or reduce a dependency or an addiction to tobacco including, but not limited to, the cessation or termination of cigarette, cigar, or tobacco smoking or the use of smokeless tobacco, including nicotine products, gums and transdermal patches; or
7. Medications for the treatment of hair loss or for the purpose of regrowing lost hair, such as Rogaine, Minoxidil; or
8. Immunization agents, biological sera, blood or blood plasma; or
9. Experimental or Investigational Medication; or
10. Medications that are dispensed to treat a Illness or Injury which arises out of or in the course of any employment for wage or profit; or
11. Medications for the treatment or obesity or diet control; or
12. [Medications taken, prescribed or administered while an Inpatient at a Hospital, Rest Home, Sanitarium, Skilled Nursing Facility, Convalescent Hospital, Nursing Home or similar institution which operates a facility for dispensing Drugs; or]
13. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use; or
14. Homeopathic medications; or
15. Any medication purchased outside the United States of America; or
16. Any Prescription Medication dispensed after twelve (12) months from the date of the Physician's original order; or
17. [Insulin, insulin syringes, needles and other diabetic supplies; or]
18. Charges which are excluded under the Policy as listed under the Policy's SECTION 4 – EXCLUSIONS AND LIMITATIONS [or]
19. [Prescription Medications purchased during the balance of the Calendar Year after the Calendar Year Maximum Benefit has been paid.]

No Benefits provided hereunder are considered Covered Benefits under the Policy's Section 3 – Benefit Provisions.

Payments of any Benefits for a condition hereunder does not waive Our rights to deny Benefits for that condition if We determine it was a Pre-existing Condition on the Covered Person's Effective Date of Coverage or if We determine the condition is otherwise not covered under the Policy.

D. DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to this Outpatient Prescription Medication Indemnity Benefit Rider. When used in this Rider these terms are capitalized:

[**Formulary Brand Drugs:** Brand-name Prescription Medications that have been determined to be superior or equal to Non-Formulary Brand Prescription Medication, but are more cost effective.]

Generic Medication: Prescription Medications that are chemically and therapeutically equivalent to Brand-name Prescription Medications in the same class but are not protected by a patent. The FDA approves Generic Prescription Medication as bioequivalent – meaning they perform in your body the same as a Formulary Brand and/or Non-Formulary Brand Prescription Medication. These Prescription Medications are generally less costly than their Brand-name counterparts.

[In-Network Pharmacy: Any pharmacy having legal authority to fill prescriptions and which has a service agreement with the Pharmacy Benefit Manager (PBM) to dispense Prescription Medications at negotiated prices.]

[**Non-Formulary Brand Drugs:** Brand-name Prescription Medications that have a more cost-effective therapeutic alternative.]

[Out-of-Network Pharmacy: A pharmacy which does not have a service agreement with the Pharmacy Benefit Manager and does not provide Prescription Medications at agreed upon prices.]

[**Outpatient Prescription Medication Calendar Year Deductible:** The amount of Covered Benefits for Outpatient Prescription Medications that each Covered Person must satisfy each Calendar Year before the Policy will begin paying Benefits for covered Prescription Medications. The Outpatient Prescription Medication Calendar Year Deductible is shown on the Schedule of Benefits. [If Formulary Brand Drugs, or Non-Formulary Brand Drugs are purchased, the Outpatient Prescription Medication Calendar Year Deductible is accumulated separately for each type of Prescription Medication purchased.] The Outpatient Prescription Medication Calendar Year Deductible is separate from the Policy's Per Illness or Injury Deductible.]]

[**Outpatient Prescription Medication Calendar Year Deductible Family Maximum:** When the amount as shown on the Schedule of Benefits is satisfied, no further Outpatient Prescription Medication Calendar Year Deductible will apply for the remainder of that Calendar Year.]

[Pharmacy Benefit Manager (PBM): The administrator contracted by Us to administer the Outpatient Prescription Medication Benefits. The PBM has contracted with retail Pharmacies across the United States to dispense Outpatient Prescription Medications at negotiated prices.]

[**Specialty Medications:** Prescription Medications that may be administered by a Physician as an Outpatient or self-administered in a home setting [and are listed on the Specialty Drug List maintained by Us or Our designee as revised from time to time].]

E. TERMINATION

Coverage under this Rider will end on [the earliest of:]

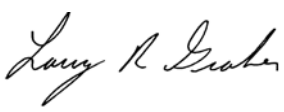
1. the date coverage under the Policy ends[; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider.]

This Rider is endorsed and made a part of the Policy/Certificate as of [its Effective Date] [August 1, 2010] [or] [Your Coverage Effective Date] [whichever is later].

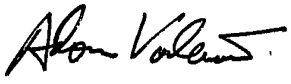
This Rider is subject to all provisions of the Policy which are not in conflict with the terms of this Rider. Nothing in this Rider will be held to vary, alter, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President



Adam C. Vandervoort
Secretary

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

[OPTIONAL] OUTPATIENT DIAGNOSTIC TESTING INDEMNITY BENEFIT RIDER

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

The Benefits provided by this Rider will not duplicate the Benefits provided under the Certificate and any other Rider and are subject to the maximum Benefit amount shown on the Schedule of Benefits. [The Per Injury or Illness Deductible applies to this Benefit and must be satisfied before Benefits are paid under this Rider.]

A. BENEFITS

When You are covered under the Outpatient Diagnostic Testing Indemnity Benefit Rider, and as shown as Included on the Schedule of Benefits, We will pay the Outpatient Diagnostic Testing Indemnity Benefit, up to the Calendar Year Maximum Benefit shown on the Schedule of Benefits, when a Covered Person receives Outpatient diagnostic X-ray or Lab Tests or Outpatient Advanced Study tests [within [15-30] days] following an Inpatient confinement or Outpatient Surgery for a covered Illness or Injury.

B. DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein.

C. TERMINATION

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends[; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made a part of the Policy/Certificate as of [its Effective Date] [August 1, 2010] [or] [Your Coverage Effective Date] [whichever is later].

This Rider is subject to all provisions of the Policy which are not in conflict with the terms of this Rider. Nothing in this Rider will be held to vary, alter, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Larry R. Graber
President

Adam C. Vandervoort
Secretary

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

AMENDATORY EXCLUSION ENDORSEMENT

This Endorsement is part of the policy/certificate to which it is attached.

In consideration for the issuance of coverage under the Policy, it is hereby understood and agreed that no Benefits will payable for:

[Any disorder of the back or spinal column, treatment there for or complications there of.]

[This applies to:

[Mary Smith]	[[9/5/47]
Name]	Date of Birth]

[Effective Date 8/1/10]

[Attached to and forming a part of Certificate No. [xxx-xxx-xxxx].]

Nothing in this Exclusion Endorsement will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

This Exclusion Endorsement is endorsed and made part of the Policy/Certificate to which it is attached as of [its Effective Date] [[August 1, 2010] or] [Your coverage Effective Date] [whichever is later]. The provisions of this Amendatory Endorsement are effective on the Effective Date stated herein and will expire concurrently with the Group Policy and Certificate unless otherwise terminated.

[Accepted by:

[*Eugene Smith*]

Insured Person

[8/1/10]

Date]

IN WITNESS WHEREOF, the Insurance Company has caused this Amendatory Endorsement to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Larry R. Graber
President

Adam C. Vandervoort
Secretary

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

RESCISSION ENDORSEMENT

This Endorsement is made a part of the Policy/Certificate to which it is attached.

There will not be coverage under the Policy, nor shall any benefit be payable for:

[Mary Smith]	[[9/5/47]
Name]	Date of Birth]

[Effective Date of this Exclusion Endorsement [8/1/10]]

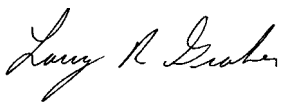
[Attached to and forming a part of Certificate No. [xxx-xxx-xxxx].]

Nothing in this Dependent Exclusion Endorsement will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

Endorsed and made a part of the Policy/Certificate to which it is attached as of [its Effective Date] [[August 1, 2010] or] [Your Coverage Effective Date] [whichever is later].

IN WITNESS WHEREOF, the Insurance Company has caused this Rescission Endorsement to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President

Adam C. Vandervoort
Secretary

FIXED HOSPITAL INDEMNITY INSURANCE BENEFIT SELECTION FORM

Underwritten by Madison National Life Insurance Company, Inc.

[CASE NUMBER _____]

Applicant's Name

Social Security Number

(Last) (First) (Initial)

PLAN SELECTION: Design your Plan by selecting your Plan options. You may select one Per Injury or Illness Deductible and then one Plan and applicable Benefit options available under each Plan. See the product brochure for details.

Per Illness or Injury Deductible [❒ $250] [❒ $500] [❒ $1,000] [❒ $1,500] [❒ $2,000] [❒ $3,000] [❒ $5,000] [❒ $7,500] [❒ $10,000]

Per Injury or Sickness Lifetime Maximum Benefit [❒ $250,000] [❒ $500,000]

[Plan 200] – Daily Room and Board Benefit [$200] / Daily Hospital Intensive Care Benefit [$600] [Must select one Benefit under each column]

[Inpatient Hospital Miscellaneous	[Inpatient Surgeon	[Outpatient Surgeon	[Outpatient Surgery Facility
❒ [$200]	❒ [$600]	❒ [$400]	❒ [$200]
❒ [$400]	❒ [$1,000]	❒ [$600]	❒ [$400]
❒ [$600]]	❒ [$2,000]]	❒ [$800]]	❒ [$600]]

[Plan 300] – Daily Room and Board Benefit [$300] / Daily Hospital Intensive Care Benefit [$900] [Must select one Benefit under each column]

[Inpatient Hospital Miscellaneous	[Inpatient Surgeon	[Outpatient Surgeon	[Outpatient Surgery Facility
❒ [$300]	❒ [$900]	❒ [$600]	❒ [$300]
❒ [$600]	❒ [$1,500]	❒ [$900]	❒ [$600]
❒ [$900]]	❒ [$3,000]]	❒ [$1,200]]	❒ [$900]]

[Plan 400] – Daily Room and Board Benefit [$400] / Daily Hospital Intensive Care Benefit [$1,200] [Must select one Benefit under each column]

[Inpatient Hospital Miscellaneous	[Inpatient Surgeon	[Outpatient Surgeon	[Outpatient Surgery Facility
❒ [$400]	❒ [$1,200]	❒ [$800]	❒ [$400]
❒ [$800]	❒ [$2,000]	❒ [$1,200]	❒ [$800]
❒ [$1,200]]	❒ [$4,000]]	❒ [$1,6000]]	❒ [$1,200]]

[Plan 500] – Daily Room and Board Benefit [$500] / Daily Hospital Intensive Care Benefit [$1,500] [Must select one Benefit under each column]

[Inpatient Hospital Miscellaneous	[Inpatient Surgeon	[Outpatient Surgeon	[Outpatient Surgery Facility
❒ [$,500]	❒ [$1,500]	❒ [$1,000]	❒ [$,500]
❒ [$1,000]	❒ [$2,500]	❒ [$1,500]	❒ [$1,000]
❒ [$1,500]]	❒ [$5,000]]	❒ [$2,000]]	❒ [$1,500]]

[Plan 600] – Daily Room and Board Benefit [$600] / Daily Hospital Intensive Care Benefit [$1,800] [Must select one Benefit under each column]

[Inpatient Hospital Miscellaneous	[Inpatient Surgeon	[Outpatient Surgeon	[Outpatient Surgery Facility
❒ [$600]	❒ [$1,800]	❒ [$1,200]	❒ [$600]
❒ [$1,200]	❒ [$3,000]	❒ [$1,800]	❒ [$1,200]
❒ [$1,800]]	❒ [$6,000]]	❒ [$2,400]]	❒ [$1,800]]

[Plan 700] – Daily Room and Board Benefit [$700] / Daily Hospital Intensive Care Benefit [$2,100] [Must select one Benefit under each column]

[Inpatient Hospital Miscellaneous	[Inpatient Surgeon	[Outpatient Surgeon	[Outpatient Surgery Facility
❒ [$700]	❒ [$2,100]	❒ [$1,400]	❒ [$700]
❒ [$1,400]	❒ [$3,500]	❒ [$2,100]	❒ [$1,400]
❒ [$2,100]]	❒ [$7,000]]	❒ [$2,800]]	❒ [$2,100]]

[Plan 800] – Daily Room and Board Benefit [$800] / Daily Hospital Intensive Care Benefit [$2,400] [Must select one Benefit under each column]

[Inpatient Hospital Miscellaneous	[Inpatient Surgeon	[Outpatient Surgeon	[Outpatient Surgery Facility
❒ [$800]	❒ [$2,400]	❒ [$1,600]	❒ [$800]
❒ [$1,600]	❒ [$4,000]	❒ [$2,400]	❒ [$1,600]
❒ [$2,400]]	❒ [$8,000]]	❒ [$3,200]]	❒ [$2,400]]

[Plan 900] – Daily Room and Board Benefit [$900] / Daily Hospital Intensive Care Benefit [$2,700] [Must select one Benefit under each column]

[Inpatient Hospital Miscellaneous	[Inpatient Surgeon	[Outpatient Surgeon	[Outpatient Surgery Facility
❒ [$900]	❒ [$2,700]	❒ [$1,800]	❒ [$900]
❒ [$1,800]	❒ [$4,500]	❒ [$2,700]	❒ [$1,800]
❒ [$2,700]]	❒ [$9,000]]	❒ [$3,600]]	❒ [$2,700]]

[Plan 1000] – Daily Room and Board Benefit [$1000] / Daily Hospital Intensive Care Benefit [$3,000] [Must select one Benefit under each column]

[Inpatient Hospital Miscellaneous	[Inpatient Surgeon	[Outpatient Surgeon	[Outpatient Surgery Facility
❒ [$1,000]	❒ [$3,000]	❒ [$2,000]	❒ [$1,000]
❒ [$2,000]	❒ [$5,000]	❒ [$3,000]	❒ [$2,000]
❒ [$3,000]]	❒ [$10,000]]	❒ [$4,000]]	❒ [$3,000]]

[**Ambulance Transport Indemnity Benefit:**	[❒ Yes ❒ No] ❒ [$250] ❒ [$500] per [conveyance] [trip] [air] [ground] [water] [occurrence]]

[**Critical Illness Deductible Waiver:**	[❒ Yes ❒ No] ❒ [50%] ❒ [100%] Of the Per Injury or Illness Deductible]

[[Optional] Indemnity Benefits:	
[Outpatient Physician Office Visit	[❒ Yes ❒ No] ❒ [$25] benefit per visit, [[1] visit per adult/[2] visits per child per calendar year] ❒ [$50] benefit per visit, [[2] visits per adult/[4] visits per child per calendar year]
[Outpatient Prescription Medication Benefit	[❒ Yes ❒ No] [❒ [$50] ❒ [$250] Prescription Deductible] [Limited to: ❒ [2] ❒ [4] ❒ [6] [Generic] Medications per calendar year ❒ [2] ❒ [4] ❒ [6] [Formulary Brand] Medications per calendar year ❒ [2] ❒ [4] ❒ [6] [Non-Formulary Brand] Medications per calendar year ❒ [2] ❒ [4] ❒ [6] [Specialty] Medications per calendar year]]
[Outpatient Diagnostic Testing Benefit	[❒ Yes ❒ No] [❒ [$50] ❒ [$75] ❒ [$100] per [test] [visit] Outpatient X-ray and Lab Tests] [❒ [$250] ❒ [$500] ❒ [$1,000] per [test] [visit] Advanced Study Tests]]
[Inpatient Confinement Enhancement Benefit	[❒ Yes ❒ No] [Exceeds: [❒ [30] days [❒ [60] days [❒ [90] days of confinement during a Period of Treatment]]
[Emergency Room Benefit	[❒ Yes ❒ No]
[Preventive Care Benefit	[❒ Yes ❒ No] [❒ [$100] ❒ [$400] per [visit] [test] [[2] per calendar year]]

Attach this form to your Application for Fixed Hospital Indemnity Health Insurance

[For Administrative Use Only							Other:]
Case Number	Enter	Date	Approved By	Date	Eff Date	PCEFDT	
_____	_____	_____	_____	_____	_____	_____	

APPLICATION FOR FIXED HOSPITAL INDEMNITY HEALTH INSURANCE

Underwritten by Madison National Life Insurance Company, Inc. – A Wisconsin Corporation

Applicant Information

Applicant's Name			Home Telephone	Work Telephone

Home Address			Billing Address		
City	**State**	**ZIP Code**	**City**	**State**	**ZIP Code**

Marital Status	Gender	Date of Birth	Height / Weight	State of Birth	Social Security Number
☐ Single ☐ Married	☐ Male ☐ Female				

E-mail Address

Dependent Information (complete only for dependents to be covered under this plan)

Name(s) Dependent (First and Last)	Social Security #	Relationship	Gender	Date of Birth	Height / Weight	State of Birth	[Full-time Student?
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

Requested Effective Date

[☐ I request the Company assign my effective date to be the 1st of the month following approval.]

[☐ I request an effective date of _____ following approval (must be the [1st] [8th] [15th] or [22nd] of the month).]

[Occupation

Is the Applicant or Spouse (if applying for coverage) employed in a restricted occupation (see Field Guide for listing)?	Applicant ☐ Yes ☐ No	Spouse ☐ Yes ☐ No]

[Tobacco Use

Has the Applicant used tobacco or tobacco cessation products during the past [12] months?	Applicant ☐ Yes ☐ No	Indicate types of tobacco/cessation products and frequency of use
Has the Spouse (if applying for coverage) used tobacco or tobacco cessation products during the past [12] months?	Spouse ☐ Yes ☐ No	Indicate types of tobacco/cessation products and frequency of use]

Medical Qualifying Questions

1. Is any person whether or not they are applying for coverage, pregnant, in the process of adoption, or undergoing infertility treatment or use of a surrogate mother? If yes, coverage cannot be issued to any family member.
☐ Yes ☐ No

If any person applying for coverage answers "Yes" to any condition(s) under question 2 they are not eligible for coverage.

2. In the past [5] years has any person applying for coverage been diagnosed with, received medical advice or treatment for, or had symptoms of, any of the following conditions:

☐ Yes ☐ No	a) Heart disease, stroke, transient ischemic attack, coronary artery disease, peripheral vascular disease, carotid artery disease, coronary bypass, angioplasty or stent, atherosclerosis, or congenital heart disease that has not been surgically corrected
☐ Yes ☐ No	b) Cancer (other than basal or squamous cell skin cancer), or malignant melanoma
☐ Yes ☐ No	c) Disease or disorder of the brain or central nervous system including but not limited to brain tumor or cyst, muscular dystrophy, multiple sclerosis, cerebral palsy, mental retardation, chorea (Huntington's, Sydenham's or Wilson's Disease or other) or amyotrophic lateral sclerosis
☐ Yes ☐ No	d) Emphysema, chronic obstructive lung disease (COPD), cystic fibrosis or other chronic lung or respiratory condition (except for asthma or allergies)
☐ Yes ☐ No	e) Hepatitis B or C, cirrhosis, enlarged liver, liver tumor or hemangioma
☐ Yes ☐ No	f) Insulin dependent diabetes mellitus or chronic pancreatitis
☐ Yes ☐ No	g) Alcoholism, alcohol abuse, illegal drug use or prescription drug dependence or addiction
☐ Yes ☐ No	h) Bipolar disorder, schizophrenia, anorexia, bulimia, suicide attempt or other mental or nervous disorder (excluding situational depression, anxiety or attention deficit hyperactivity disorder, ADHD)
☐ Yes ☐ No	i) Kidney or bladder disorder (excluding resolved stones or urinary tract infections)
☐ Yes ☐ No	j) Rheumatoid or psoriatic arthritis, quadriplegia, paraplegia, or are you required to use a wheelchair or other device to assist you in ambulation
☐ Yes ☐ No	k) Stem cell transplant, organ transplant or disease of the blood (other than iron deficiency anemia)
☐ Yes ☐ No	l) Autoimmune disorder including but not limited to systemic lupus erythematosis, dermatomyositis, Sjoren syndrome or myasthenia gravis
☐ Yes ☐ No	m) Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or tested positive for the HIV virus

3. In the past [5] years has any person applying for coverage been diagnosed with, received medical advice or treatment for, or had symptoms of, any of the following conditions (please provide details on the following page):

☐ Yes ☐ No	a) Herniated or bulging disk, degenerative disk disease of the spine or other chronic back condition
☐ Yes ☐ No	b) Ulcerative colitis, Crohn's disease, terminal ileitis, diverticulitis or other colon or intestinal disorder
☐ Yes ☐ No	c) Gall bladder disease that has not been cured and/or gall stones that have not been removed
☐ Yes ☐ No	d) Stomach or digestive track disorders
☐ Yes ☐ No	e) Endometriosis, human papilloma virus or chronic menstrual disorder without undergoing a total hysterectomy
☐ Yes ☐ No	f) Degenerative joint disease or replacement of the hip(s) or knee(s)
☐ Yes ☐ No	g) Type II diabetes

4. In the past [5] years has the applicant or spouse (if applying for coverage) been diagnosed with, received medical advice or treatment for, or had symptoms of any of the following conditions:

☐ Yes ☐ No	Hypertension	If Yes, at which level was your most recent blood pressure reading:			
	Applicant:	☐ [140/90] or below	☐ [141-155]/[91-95]	☐ Over [155/96]	Date of last reading:_____
	Spouse:	☐ [140/90] or below	☐ [141-155]/[91-95]	☐ Over [155/96]	Date of last reading:_____
☐ Yes ☐ No	High Cholesterol or triglycerides	If Yes, at which level was your most recent cholesterol reading:			
	Applicant:	☐ Under [260] mg/dcl	☐ [260-300] mg/dcl	☐ Over [300] mg/dcl	Date of last reading:_____
	Spouse:	☐ Under [260] mg/dcl	☐ [260-300] mg/dcl	☐ Over [300] mg/dcl	Date of last reading:_____

Medical Qualifying Questions Details

INSTRUCTIONS: Please complete the following details for any "Yes" answers to questions 2 and 3 under the Medical Qualifying Questions' section on the previous page. If more space is needed, please use a separate sheet of paper and sign and date all attachments.

Question #	Person's Name

Question #	Person's Name

Producer Information

Are you licensed in the state where the application was completed? ☐ Yes ☐ No

Are you currently appointed with Madison National Life Insurance Company, Inc., in the state where the application was completed? ☐ Yes ☐ No

Producer's Name		Company		
Address		City	State	ZIP Code
Phone	Producer Number	E-mail Address		

PRODUCER'S STATEMENT: I certify that I have truly and accurately recorded all the information given to me by the applicant and I know of no other medical information about those persons applying for coverage other than that contained on this application. I understand that commissions cannot be paid unless appointed with Madison National Life Insurance Company, Inc..

Signature of Producer	Date

AGREEMENT & SIGNATURE

INSTRUCTIONS: **Read the following information and signify your agreement with the terms of this agreement for insurance by signing and dating the application as indicated below.**

Premium Payment: I agree that (1) I am responsible for making the proper monthly premium payments; (2) a grace period of 31 days is allowed for any premium due after the first premium and if such premium is not paid before the expiration of the 31 days grace period, coverage for all insured persons shall lapse as of the premium due date; (3) any negotiable premium checks received in an envelope postmarked after the thirty-one day grace period will be refunded less any amounts due (if any) from previous months; (4) negotiation of any check from or on behalf of the insured shall not constitute acceptance of premium as premium is only accepted when acknowledged and applied by insurer. There is a one-time, non-refundable application fee.

Pre-certification and Signature: I agree that failure to pre-certify treatment, if required, may result in reduced benefits pursuant to the terms of the master policy.

U.S. Resident: I understand that the coverage under this plan is available to United States residents only. Benefits are not payable for medical expenses outside of the United States except for emergency care when traveling. If I stay outside the United States for more than 90 days, I will be deemed to be residing outside of the United States and not traveling.

Application for group plan membership: I understand that I am applying as an individual for membership to the [America's Business Benefit Association] and am simultaneously applying for insurance to which I am now or may become eligible for under the provisions of the Group Master Policy issued to [America's Business Benefit Association] by Madison National Life Insurance Company, Inc. I understand that my application is subject to medical underwriting and approval by Madison National Life Insurance Company, Inc., or its authorized administrator in accordance with the underwriting guidelines in effect. I understand this basic coverage is not an employer health plan and I certify that (a) premiums are being paid by me as a personal expense and, neither my employer nor the employer of my dependents is now or in the future will be paying any part of the premium either directly or through wage adjustments or otherwise and (b) to the best of my knowledge and belief my employer has not and will not maintain, endorse or represent this basic health plan as an employer health insurance plan for any purpose, including a tax deduction. Individuals not meeting this certification above are not eligible for coverage. I further understand that acceptance of the check submitted with this application does not constitute approval or guarantee of coverage.

Updated Information: I agree to immediately notify Madison National Life Insurance Company, Inc., or its authorized administrator if there is any change in my health or the health of my dependents that would require a change in the answers provided in this application prior to being notified of approval of this application.

My answers are true, complete and correct: I have personally reviewed all of my answers to the questions on this application and any attachments to it and certify that all of the information I have provided is true, complete and correct, I agree that it is my responsibility to provide truthful, complete and correct information. I certify I fully understand the questions asked. I agree that any material misstatements or failure to report information may be used as the basis of rescission or reformation of coverage for me or my dependents, if any. I agree that under no circumstances is any agent allowed to: (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any question; or (c) instruct me not to disclose any particular medical condition on the application. I agree that no agent is authorized or has the authority to alter the terms of the Group Master Policy.

Attachments: I understand that any attachments to this application become a part of it.

DO NOT CANCEL ANY EXISTING HEALTH INSURANCE UNTIL RECEIVING WRITTEN NOTICE OF APPROVAL.

[Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.]

[District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

I understand this is a limited benefit hospital indemnity plan. I have reviewed and understand the policy's benefits, limitations, and exclusions, [including pre-existing condition limitation provision]. [I understand that the Benefits for a pre-existing condition will be subject to the pre-existing condition limitation for up to [12] months].

[I attest that the information provided above is true, complete and correct. Dated at:

City	State	Day	Month	Year

Name of Applicant or parent, if applicant is under age [18] (print)	Signature of Applicant	Date

Name of Spouse if applying for coverage (print)	Signature of Spouse if applying for coverage	Date

Submit to Madison National Life Insurance Company, Inc.
[1173 W. Main St. Ste E Whitewater, WI 53190]
[Fax No. 866-570-5234]

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

[**P.O. Box 5008, Madison, WI 53705**]

APPLICATION FOR GROUP INSURANCE

GROUP POLICY NUMBER [XX-XXXX]

Application is hereby made to Madison National Life Insurance Company, Inc., for Group Insurance Benefits in the Policy form attached to and made a part hereof; and if this application is accepted by Madison National Life Insurance Company, Inc., the Policy shall be issued to:

Name of Applicant: [ABC Association]

State of Delivery: [State]

To be effective 12:01 A.M. on the 1st day of [June 1, 2010].

Applicant's Signature: _____[Jane Doe]_____

Title: _____[President]_____

Date: _____[June 1, 2010]__

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

AMENDATORY ENDORSEMENT
(Applies to Eligible Person [and Eligible Person's Covered Dependent Spouse] only)

Notwithstanding anything in the Policy and Certificate of Insurance to the contrary, it is hereby understood and agreed that the Policy and any Certificate of Insurance to which this amendatory endorsement is attached are amended as follows:

A. **Section 3 – BENEFITS**, the following change is hereby made:

The first sentence in the first paragraph pertaining to all Covered Benefits being the result of non-occupational Illness or Injury is deleted and replaced with the following:

All Covered Benefits must be as a result of a non-occupational Illness or Injury while covered under the Policy; except that Covered Benefits may be a result of an occupational Illness or Injury of an Eligible Person [and the Eligible Person's Covered Dependent Spouse], while covered under the Policy, who is a sole proprietor, partner, or owner eligible under state law to legally elect to not be covered under Workers' Compensation and who is not insured under any Workers' Compensation Law or Occupational Disease Law. Coverage for occupational Injury or Illness of a sole proprietor, partner or owner is not intended to take the place of Workers' Compensation Insurance.

B. **Section 4 – EXCLUSIONS and LIMITATIONS**, the following change is hereby made:

Item 9 pertaining to an employment related Illness or Injury is deleted and replaced with the following:

9. An Illness or Injury which arises out of or in the course of any employment for wage or profit or an Illness or Injury for which the Eligible Person [or the Eligible Person's Covered Dependent Spouse] has or had a right to recovery under any Workers' Compensation or Occupational Disease Law. This exclusion does not apply to an employment related Injury or Illness of an Eligible Person [and the Eligible Person's Covered Dependent Spouse] who is a sole proprietor, partner, or owner eligible under state law to legally elect to not be covered under Workers' Compensation and who is not insured under, and who does not have or had a right to recovery for such employment related Injury or Illness under any Workers' Compensation Law or Occupational Disease Law;

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Larry R. Graber
President

Adam C. Vandervoort
Secretary

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

ARKANSAS AMENDATORY ENDORSEMENT

Notwithstanding anything in the Policy and Certificate of Insurance to the contrary, it is hereby understood and agreed that the Policy and any Certificate of Insurance to which this amendatory endorsement is attached are amended for residents of Arkansas as follows:

A. **Section 2 – Eligibility and Effective Dates**, **Dependents Acquired After the Eligible Person's Coverage Effective Date**, the following changes are hereby made:

1. The paragraph pertaining to a newborn Child is deleted and replaced with the following:

   A newborn Child of an Eligible Person will become insured automatically from the moment of birth and coverage will remain in force for 90 days. Coverage for newborns shall be the same as for all other Dependents. You must notify Us in writing within 90 days of such birth, and pay the required additional premium, if any, in order to have coverage for the newborn Child continue beyond such 90 days.

2. The paragraph pertaining to an adopted Child or a Child placed for adoption is deleted and replaced with the following:

   An adopted Child or a minor under Your charge, care and control for whom You have filed a petition to adopt, is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the Child for purposes of adoption. Coverage for such Child will be the same as for all other Dependents. Coverage will continue unless the placement is disrupted prior to legal adoption and the Child is removed from placement. However, You must notify Us in writing within 60 days of such placement for adoption or entry of an order and pay the required additional premium, if any, in order to have coverage for the adopted Child continue beyond such 60 day period.

B. **Section 5 – Termination of Insurance, Termination of a Dependent's Coverage**, the following change is hereby made:

1. Item 9. a., pertaining to medical proof is deleted and replaced with the following:

   a. Medical proof, in writing, of such incapacity must be given to Us after the date on which the Dependent Child attains a limiting age.

C. **Section [8] – General Provisions**, the following change is hereby made:

1. **Recovery of Overpayments**, the following is added:

   Except in cases of fraud committed by a health care provider, We may exercise recoupment from a provider only during the 18 month period after the date We paid the claim submitted by the health care provider. If We exercise recoupment, We shall give the health care provider a written or electronic statement specifying the basis for the recoupment. The statement will provide the following information: (a) the amount of the recoupment; (b) the Covered Person's name to whom the recoupment applies; (c) the patient identification number; (d) the date of date of service; (e) the service or services on which the recoupment is based; (f) the pending claims being recouped or future claims that will be recouped; and (g) the specific reasons for the recoupment.

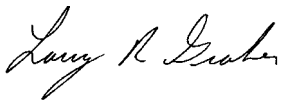
   For the purpose of this provision, the following definition is added:

   Recoupment means any action or attempt by a health care insurer to recover or collect payments already made to the health care provider with respect to a claim: (a) by reducing other payments currently owed to the health care provider; (b) by withholding or setting off the amount against current or future payments to the health care provider; (c) by demanding payment back from a health care provider for a claim already paid; or (d) by any other manner that reduces or affects the future claim payments to the health care provider.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President

Adam C. Vandervoort
Secretary

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

POLICYHOLDER ELECTION FORM
ARKANSAS RESIDENTS ONLY

As elected by the Policyholder, Covered Benefits will include all or any of the following:

Accept _____ Reject _____ Disorders of the face, neck and head (23-79-150)

As the Policyholder, we request that you indicate above whether you accept or reject these optional benefits:

Rejection of this option means that covered benefit provided to the Covered Person will not include temporomandibular joint (TMJ) disorder of craniomandibular disorder.

Policyholder Name: _____

Signed for the Policyholder _____

Name _____ Title _____ Date _____

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

AMENDATORY ENDORSEMENT

(Applicable to the Arkansas Residents Only)

As elected by the Policyholder, Covered Benefits will include the following:

The following is added to **Section 3 Benefit Provisions**:

State Mandates
We will pay the following state mandate as applicable to the specific Benefit or Benefits in Section 3 of the Certificate of Insurance and any Benefit Rider shown as Included in the Schedule of Benefits. The mandates are subject to the terms, conditions, limitations and exclusions of the Policy, Certificate of Insurance, any Included Benefit Riders and the Schedule of Benefits. The specific Benefit must be shown as Included in the Schedule of Benefits in order for the mandate listed below to be a Covered Benefit. The state mandate will be paid as shown for the specific Policy benefit in Section 3 of the Certificate of Insurance, any Benefit Rider shown as Included in the Schedule of Benefits. Benefits payable for the state mandate will not exceed the maximums and limitations shown in the Schedule of Benefits.

Covered Benefits include medical treatment of musculoskeletal disorders affecting any bone or joint of the face, neck, or head, including temporomandibular joint disorder (TMJ). Coverage includes both surgical and nonsurgical treatment for medically necessary diagnosis and treatment of these conditions whether they are a result of accident, trauma, congenital defect, developmental defect, or pathology, and shall be provided whether prescribed or administered by a physician or dentist.

Exclusion #43 pertaining to temporomandibular joint dysfunction (TMJ) is deleted in its entirety.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Larry R. Graber
President

Adam C. Vandervoort
Secretary

SERFF Tracking Number:	*ICCI-126869662*	*State:*	*Arkansas*
Filing Company:	*Madison National Life Insurance Company, Inc.*	*State Tracking Number:*	*47297*
Company Tracking Number:	*MNL MMHI POL D610*		
TOI:	*H14G Group Health - Hospital Indemnity*	*Sub-TOI:*	*H14G.000 Health - Hospital Indemnity*
Product Name:	*MNL MMHI POL D610 - Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/MNL MMHI POL D610*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/22/2010

Comments:

Attachment:

Cert of Comp. with Rule 19 MNL MMHI D610.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	11/22/2010

Comments:

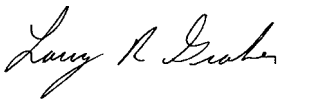
The applications are included in the form schedule tab

Certificate of Compliance with
Arkansas Rule and Regulation 19

Insurer: Madison National Life Insurance Company, Inc.

Form Number(s): MNL MMHI POL D610, MNL HIGAPP 610, MNL HICERT D0610, MNL HIAR AE 610, MNL HI/FI AE 1010, MNL OPT ELC AR 610, MNL AEAR OPT TMJ 610, MNL HIEXCL 610, MNL HIRE 610, MNL HIER 610, MNL HIICE 610, MNL HIPCBR 610, MNL HIPOV 610, MNL HIRXBR 610, MNL HITEST 610, MNL HIAPP 610, MNL HIBSF 610

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.



Signature of Company Officer

Larry R. Graber
Name

President
Title

November 11, 2010
Date

SERFF Tracking Number:	*ICCI-126869662*	*State:*	*Arkansas*
Filing Company:	*Madison National Life Insurance Company, Inc.*	*State Tracking Number:*	*47297*
Company Tracking Number:	*MNL MMHI POL D610*		
TOI:	*H14G Group Health - Hospital Indemnity*	*Sub-TOI:*	*H14G.000 Health - Hospital Indemnity*
Product Name:	*MNL MMHI POL D610 - Hospital Indemnity Policy*		
Project Name/Number:	*Hospital Indemnity Policy/MNL MMHI POL D610*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/11/2010	Form	Group Policyholder Election form for TMJ	11/22/2010	AR MNL OPT ELC AR 610 _Optional Election form_.pdf (Superceded)

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

POLICYHOLDER ELECTION FORM
ARKANSAS RESIDENTS ONLY

As elected by the Policyholder, Covered Benefits will include all or any of the following:

Accept _____ Reject _____ Disorders of the face, neck and head (23-79-150)

As the Policyholder, we request that you indicate above whether you accept or reject these optional benefits:

Policyholder Name: _____

Signed for the Policyholder _____

Name _____ Title _____ Date _____